STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATE OF NEED COMMISSION

COMMISSION MEETING

BEFORE JAMES FALAHEE, CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, January 26, 2023, 9:30 a.m.

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MR. FALAHEE: So I'm sorry to stop the discussions in the audience. It's nice to see so many friendly faces, familiar faces. My name is James -- if anybody calls me James, I know it's a sales call -- the nickname is Chip Falahee. It's my pleasure to be the chairman once again of the Commission for the, I don't know, fourth, fifth, sixth time, I'm not sure. Before we call the meeting to order, I want to -- I want to thank Dr. McKenzie to my left. Our cards still say that I'm the vice chair and she's the chair, but we're not going to take a Sharpie and correct it. But I want to thank her for her service as chair. It's -- I know from experience it's not easy being chair and taking all the phone calls and the e-mails, so I want to thank her personally. Thank you, Amy, for that. Appreciate it.

DR. MCKENZIE: Thanks, Chip.

MR. FALAHEE: So let's call this meeting to order. The first item on the agenda is the review of the agenda. We've got the packet, the agenda in front of us. For those in the audience, the packet this time was 224 pages and it was a friendly slog through all of that documentation, so -- and I can guarantee you we've gone through it. So the first item is the review of the agenda. I'd like to make one potential change and if it's okay with the Commission to

approve that change? We have one witness today is a physician from the University of Michigan and he has time commitments back in Ann Arbor. So I said to Steve Szelag this morning that I'd be fine with it and I spoke with the Department yesterday to take that physician out of order to present on something to do related to MRT having to do with proton beam. So we'll take that witness and that witness only out of order once we finish with the review of the minutes, then we'll go bak to the regular agenda. We'll cover MRT where it is right now in the agenda which is agenda item eight. So that would be the one change I would make to the agenda. With that, is there a motion to approve the revised agenda as I just described it?

DR. MACALLISTER: Commissioner Macallister. So moved.

DR. MCKENZIE: Commissioner McKenzie. Second.

MR. FALAHEE: Okay. Motion made and seconded to approve the revised agenda. All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Great. Any opposed? Okay. Thank you.

(Whereupon motion passed at 9:33 a.m.)

MR. FALAHEE: And as a side note we've all got microphones in front of us so we can all hear each other and hopefully, if not always, you might want to hear what we're

saying as well. So just a couple comments. First let's do declaration of conflicts of interest. Let me get that out of the way. Does anyone have on the Commission a conflict of interest they wish to declare given the agenda in front of us today? Hearing none, we'll move on. Review of minutes. We last met on December 8. The minutes are in the packet. Any comments? Otherwise, I'd entertain a motion to accept the minutes as presented.

DR. MCKENZIE: Commissioner McKenzie. Motion to accept the minutes.

DR. KONDUR: Second to accept. Commissioner Kondur.

MR. FALAHEE: Great. Motion made, seconded to accept the minutes as presented. All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? Great.

(Whereupon motion passed at 9:34 a.m.)

MR. FALAHEE: Just some housekeeping items before we go into our first witness/commenter. As you all know and for any new in the audience, if you're coming up to testify at the podium, the witnesses are subject to three minutes time limit and after three minutes a little bell will go off and I'll get a high sign and we'll ask you to summarize and close your comments up. We do that out of respect for all the witnesses, especially today. I know we've got a lot of

blue cards being submitted so we do that out of respect for everyone and we treat every witness the same. We've had members of the legislature here, three minutes. So that's how we approach it. Also, sometimes when we have multiple blue cards in, some of those people just want to say the same thing that somebody else just said. It's not a number of witnesses that help the Commission decide whether to say yea or nay or agree to something. So if your purpose of getting up is just say what she said or he said I agree with, you don't need to do that. Secondly, or thirdly, when I've been chairman before -- and I know I speak on behalf of the Commissioners -- as I said, we've got a very extensive packet. We do that every time. And we frown on last minute additions to that packet, last minute handouts, e-mails the night before. That comes in too late and doesn't give us the time to digest it, understand it, talk to the Department about it. And if you've got something that you want to say, you've got the chance to come to the podium during the meeting and speak for three minutes. So just sensitivity on behalf of the Commission to everyone about that.

Just to tee up today's meeting. This is a -- we call it a special meeting because meetings every January, they're a little bit different. I look at it more of sort of the CON strategic planning meeting. As we all know, the CON standards are up for review every three years. This is

the meeting where we consider those that are up for review in this calendar year. And what we do every October before that is we send out request for public comments. Dear public, here are the standards that are coming up for review. What comments do you have about them, good, bad, indifferent? What should we as the Commission with the Department look at? So that's where that starts and that's where it culminates here with suggestions for the Department and for the Commission to look at certain standards, consider changes to the standards, consider adding new things to the standards and that's all well and good to keep the standards current and reflective of what's going on around us. And as we all know, health care is changing rapidly so it's good to keep the standards as current as possible based on reliable data and what happens as a result of that is that the Department works with the Commission to say here's what we think needs to be done. The Commission then hears from witnesses and says, okay, here's what the Commission wants to do and the result of that is that either we can instruct the Department to do nothing, we can instruct the Department to come up with some technical wording changes, we can agree on a workgroup to be created to look at an issue or issues, or we can agree on a SAC. The SAC, Standards Advisory Committee, that's a more formal body than the workgroup. SACs are subject to the Open

Meetings Act like we are so you've got to be in person. You can't be Zooming. Workgroups are not subject to the Open Meetings Act. So that's what we're going to be talking about today with the various issues we've got on our agenda; do we appoint a SAC, a workgroup, technical workgroup, whatever. So that's -- I just want to tee that up so everybody understands what we're talking about here. Any questions amongst the commissioners or comments? Okay.

If not, then I'll turn to our first out of order witness from the University of Michigan. So and "out of order" just means he's taking -- being taken out of order not that he himself is out of order.

MR. WIRTH: And I do want to mention real quick just two announcements real fast. We did find an orange bank card. If anyone's missing a debit card, let me know and we can make sure that we get that back to the owner.

MR. FALAHEE: Oh, we found it. Hang on. The owner has --

MR. WIRTH: All right. And secondly, if you are going to submit a blue card while the meeting is going on, please pass that either to Marcus Connolly or Kate Tosto. All right. And so now we have Dr. Daniel Chang from U of M.

DANIEL CHANG, M.D.

DR. DANIEL CHANG: Thank you, everyone. Thank you for to the Commission for allowing me to speak here and for

going out of order to accommodate my schedule.

I recently became the chair of the University of Michigan, Department of Radiation Oncology. I'm here this morning to request that the Commission reevaluate the Certificate of Need standards governing proton radiotherapy. Radiation is one of three pillars of cancer therapy alongside surgery and chemotherapy. External beam radiation with high energy photons is what the vast majority of radiation patients receive. Proton therapy on the other hand is a very -- is very different photons in how it penetrates and interacts with tissue. Photons deposit energy from the moment they enter the body to the moment they leave, thereby causing damage to healthy tissue and normal tissue, similar to how you might think about how a bullet enters a body that causes damage at the moment it enters to the moment it exits. Protons on the other hand could be more likened to a very precise mini grenade in that it can deposit the vast majority of its energy at a very precise and specified depth, then stops with very little entrance and no exit dose damage.

For about two decades, the US only had two proton facilities that were treating patients and this was primarily because of two factors. One is that proton therapies were very expensive, easily in the 150,- to $250 million range to build a center. And number two, the

clinical evidence for proton therapy was lacking. In the last 15 years or so there's been an explosion in proton therapy centers in the US and around the world. And there was a healthy and appropriate degree of skepticism that adopting protons was premature, not evidence-based, and likely maybe focused or more driven by some financial reasons. As such, the public perception of protons was deeply rooted in the skepticism and I would probably say that some current CON standards that states have used and adopted have been probably strict for a good reason.

However, more recently the proton industry has committed more resources to reduce the cost of proton therapy. Whereas before the only option was these very large four to five room centers built from scratch at a nine figure price tag, single room proton therapy solutions have become available and now there's technology that was recently announced that could fit in a current proton therapy -- sorry, could fit proton therapy into a current photon therapy vault meaning that you don't have to build new centers and you could probably create these at about ten percent or so of the cost of one of those large proton therapy behemoths from the past.

At the same time, we've gained more experience and more importantly more data to support proton therapy and how it improves toxicity and reduces side effects. In just the

last two years alone, there have been two published randomized trials showing protons to be better than photon therapy so the data is now finally catching up and we have every reason to believe that this trend will continue.

We believe proton therapy is critically important as a treatment option to offer residents of Michigan. Patients that stand to benefit the most are children because they can be spared the serious and sometimes horrifying long-term risks of radiation including growth, abnormalities, and second cancers that result from radiation. Childhood cancers thankfully are very curable with radiation but can be heartbreaking --

MR. WIRTH: That's three minutes.

DR. DANIEL CHANG: Three minutes? All right. Okay.

MR. WIRTH: Sorry.

DR. DANIEL CHANG: All I'll say is that right now we believe that the University of Michigan is in a good position to be able to offer protons because of our integration with a full service children's hospital and we believe that now is a critical time to offer that because many of these children are being sent out of state which can be very difficult for families to able to cope with. So with that, I'll close.

MR. FALAHEE: Thank you very much. Any questions?

So I have one question. This is Commissioner Falahee. So your recommendation is that when we consider the MRT agenda items or charges, if you will, to consider adding to those charges the issue of proton beam and whether we should look at amending the standards in Michigan? Is that what I take it or --

DR. DANIEL CHANG: Yeah. So, yeah, our recommendation is that we review those standards because right now we find them to be overly strict and difficult. We believe -- so I'm relatively new to Michigan. My understanding, though, is that from past history of attempts to try to bring protons there was requirements of having to have certain centers that had a certain number of threshold of visits and then needs for consortiums and those types of things whereas perhaps it may be -- it may be worthwhile to reconsider whether those are necessary given that the University of Michigan itself through its own network does have a very large number of visits that touches a very broad area of geographic footprint of the state of Michigan. But I think also just the fact that financially the barriers have come down dramatically and there's clear need because right now patients are being sent out of state to other places in order to get the therapy.

MR. FALAHEE: Okay. Thank you.

MS. GUIDO-ALLEN: I do have one. Commissioner

Guido-Allen. So the Commission, the CON also has limitations on bone marrow which Michigan is one of the sites that allows it. How is your request to open up the CON for proton different than the requests that have been made in the past around bone marrow? I understand you're new to Michigan.

DR. DANIEL CHANG: Yeah. Well, I guess I -- I guess what I would say is that it's a -- this particular -- I'm not a -- I'm not a bone marrow expert. So what I can say about protons is that I think the landscape has changed pretty dramatically over the last three to four to five years depending how far you want to go back. But I think that right now there seems to be this kind of overall sort of momentum that -- driven mostly by data now that we have prospective, randomized face-free data which is something that was lacking up until about two years ago. I think that is probably the biggest thing that we want to be able to stand on to say that this clearly shows benefit to the patients that we can treat. I don't exactly know the interplay between how bone marrow and proton therapy may interact with each other, but for us because we take care of children and -- through the Mott's Children Hospital, there is going to be -- that is where, you know, the most complex cases that probably would benefit the most from proton therapy come.

MR. FALAHEE: Other questions? Thank you very much. Welcome to Michigan. Welcome to the joy of CON. With that, we'll go back to the Roman numeral agenda in front of us. And, Kenny, before we talk about and get public comment on the psych beds and services, do you or Kate or Marcus want to say anything, summarize what's going on, where we've been?

MR. WIRTH: Yeah. I do wish to summarize, and then we do have a number of public comments and I'm sure that they will fill in any gaps that I leave.

So if you all recall at the December 8th, 2022 meeting of the CON Commission, the Commission voted to bifurcate the definition for medical psychiatric unit and charged the Department with developing language regarding acute care settings with external stakeholders for you at the January 26 meeting and to then charge an informal workgroup with creating the definition for medical psychiatric in a freestanding setting.

So as a reminder, the issue that we're facing right now is that CON has approved some modifications for medical psychiatric units within freestanding settings, however, Licensing and Regulatory Affairs will only license a med psych unit within an acute care setting. So my understanding is it boils down to a conflict between CON review standards and LARA statute. So we need to figure out

how to make it so it'll work in a freestanding.

So the psych beds and services informal workgroup focused on freestanding settings met on January 19th and is requesting that the Commission provide some more guidance on the assigned charge. The workgroup would like to know if they are strictly limited to Section 1.4 of the psych beds and services addendum, or if they are able to create a new definition within Section 1 for a freestanding medical psychiatric unit. The previous charge was very narrow in scope and I think that kind of threw a little bit of a wrench into the works. Additionally, the workgroup would appreciate clarification from the Commission on the intended use of the medical psychiatric unit beds when the med psych units were created within the review standards as a special pool. Sometime in 2015 or 2016 I think those were added. Secondly, the Department is recommending that the Commission hold a vote today to add to the informal workgroup's charge to amend the medical psychiatric unit definition to prevent med psych units in acute care settings as well as in freestanding settings so the workgroup can tackle both, essentially undo the bifurcation and have the workgroup look at both things. And that's what I have on that, so --

MR. FALAHEE: Before we open it up for public comment, the reason I wanted Kenny to summarize it is because there have been some changes since the workgroup

started to dig into this and now we see the potential conflict between LARA and MDHHS so we're learning more. And as we're learn more, the beauty of a flexible charge, if you will, is we can add charges to a workgroup or a SAC. There are requirements on how to do that, but that's the beauty of it. So that's what -- anybody have any questions before we open it up for public comment? Okay. Great. Then we'll open it up for public comment. Thank you, Kenny.

MR. WIRTH: Sure. First one I have is Dr. Jain with Corewell.

MR. FALAHEE: Dr. Jain is becoming a familiar face at these Commission meetings whether he wants to or not. Welcome back.

DR. SUBODH JAIN: Thank you. Thanks for having me.

SUBODH JAIN, M.D.

DR. SUBODH JAIN: Good morning. Thank you, Chairperson Falahee; thank you, Vice Chair Dr. McKenzie, and members of this Commission. My name is Subodh Jain. I'm here on behalf of Corewell Health. I'm the chief of psychiatry and behavioral medicine there. And as the chair of CON Psych Beds workgroup.

So since the December meeting I have been working with stakeholders to revise the definition of medical psychiatry unit to allow the flexibility for acute care

hospitals to provide critical behavioral health services to those in urgent need who could not be placed in a general psychiatry bed.

So if you noticed since 2015 or 2016, the world has completely changed since the pandemic for all health care and especially for mental health care. So the resources are leaner, workforce is scarce, and infectious diseases are prevalent. So what that says is the difference between a psychiatry bed and a med psych bed is not as black and white. It's grayer. So I believe we're close to an agreement around the definition as it relates to acute care hospitals. However, to ensure that we provide this flexibility while also protecting the original intent of med psych special pool, we have discovered that we need to revise more than simply the definition. Maybe a setback of this work is being recommended to workgroup form to look at the med psych special pool in freestanding facilities. I'm optimistic that we will be able to reach an agreement that puts the health and well-being of Michigan children first.

The first meeting of the workgroup formed to address the med psych definition in freestanding facilities took place last week as Kenny mentioned and resulted in good substantive discussion. Very open, very thorough discussion. I really appreciate everybody who participated there. All the solutions have not been discussed yet

because we're still trying to -- like, kind of unsurface the underlying issues with that definition itself. So I think it was very well received. So we have not actually reached the solutions and of course that's going to come -- have not been discussed yet and we are poised to start those discussions at our next meeting which is scheduled on February 16th. It is likely that the solutions on freestanding site will also require changes to more than just the definition itself just like what we are mentioned.

So, again, my request is still let us continue on the med psych and acute care hospitals. One of the angles for -- not the angles. One of the things we notice is most of the children who are even asymptomatic with respiratory or COVID illnesses or lately we have the tripledemic of RSV, influenza and COVID this fall, kids are stuck for very long time -- and adults, too, but kids especially. So those are the reasons why I think a med psych unit in acute care hospitals may have a different flavor to than what it is in the freestanding hospital. I'll be happy to answer any questions.

MR. FALAHEE: Thanks, Dr. Jain. Questions? Commissioner Ferguson?

DR. FERGUSON: Thank you. Thank you for the presentation. Could you help me understand or perhaps the Department can help me understand. Is this conversation

principally about adults, children, both? Are the two regulated separately or the same?

DR. SUBODH JAIN: They're about all age groups. The reason why we see the crisis is primarily in -- not primarily, but much worse in children.

DR. FERGUSON: Okay.

DR. SUBODH JAIN: So that's why we want to bring this issue up because whatever we decide here is going to impact the children's mental health in a long, long time.

DR. FERGUSON: Sure. So are they -- are they regulated separately or managed the same from a licensure --

MR. WIRTH: For med psych beds --

DR. FERGUSON: For -- for -- yeah.

MR. WIRTH: -- and, Tulika, correct me if I'm wrong, but I believe that med psych is just med psych; correct? There are other child and adolescent med psych beds?

MS. BHATTACHARYA: Yes. So the concept of the special pool beds is the same, but we do have two separate pool of beds, one for adults and one for child and adolescent.

DR. FERGUSON: And this is looking to address access in both arenas but I'm hearing you say that the access problem is potentially worse with children?

DR. SUBODH JAIN: Worse with children. And one of

the -- me being a representative of Corewell Health, we are looking to start a pediatric med psych unit within this year or by next year. So that's -- that is also trying to solve some of the problems, so --

MR. FALAHEE: Other questions from the Commissioners? I've got a few. Just help me understand the situation we're in. So when we talk about med psych beds -- and whether it's Dr. Jain, Tulika -- who can be admitted into those beds now? Adults and kids? No kids? How does that work?

DR. SUBODH JAIN: Anybody can be admitted to those beds if they meet the criteria of. The challenge is the language defines whether it is for somebody who needs acute treatment for wound care, dialysis. I think there are a couple more, intravenous tubing, IV lines. I think that's what the definition said earlier. So it's fairly narrow in scope and, but that we know, like, medical conditions are way beyond that. So secondly the issue is if for some of the med psych pool beds, if there is a unit open it does not allow to admit somebody who does not have medical issues acutely. So there should be a distribution that some of the more complex psychiatry patients who cannot be placed anywhere else can also be placed in some of those beds just for the need of acute care hospitals. Because I can imagine no acute care hospital is looking to open more psychiatry

only beds with med psych units. They're just trying to make sense of whatever crisis is at their hands.

MR. FALAHEE: So this is Falahee again. So we've got a situation now unlike maybe in '15 or maybe it's more well recognized than it was in '15. We've got patients coming in to emergency departments and having no place to go. If it's a truly psych only patient, they sit in the emergency department waiting for a psych admit somewhere. If it's a child or adolescent that has medical and psych issues, as I understand it now, they've got to have certain medical issues before they can be admitted to a med psych unit in that hospital or another hospital; is that right?

DR. SUBODH JAIN: That's correct.

MR. FALAHEE: Okay. And, Tulika, that is your understanding as well?

MS. BHATTACHARYA: Yes.

MR. FALAHEE: Okay. All right. So one thought is to expand the definition of med as part of the med psych unit and the other issue is what can be done in freestanding facilities vis-a-vis med psych or psych; right?

DR. SUBODH JAIN: Yes. That's correct.

MR. FALAHEE: Okay. All right.

DR. MACALLISTER: Just for clarification. And the acuity level as well of that patient in that freestanding, is that as well what you're trying to define? So is it more

of a long-term psychiatric freestanding facility as opposed to an acute, intubated patient or is that -- is that also part of the definition you're trying to define?

DR. SUBODH JAIN: So I hope I'm understanding you correctly. Your question is, is the acuity level of the patients defined in the freestanding hospitals before they're admitted to those beds?

DR. MACALLISTER: Correct; yes.

DR. SUBODH JAIN: I don't think acuity is part of it. It's specifically the medical services that they're needing for it. And I think if the patient is acute enough, they can't be in the freestanding hospitals.

DR. MACALLISTER: Right. That's why I'm --

DR. SUBODH JAIN: So we do not want to put those patients -- so we are -- like acute care hospitals should be able to take care of all of those patients who are needing to be hospitalized. I think these are the complex medical patients. For example, somebody who has very brittle seizure disorders or, you know, excessive needs in diabetes or have a wound care after they cut themselves but they can't be hospitalized overnight so they do not qualify for inpatient hospitalization, but their psychiatry needs are which can be met on the --

DR. MACALLISTER: On the outpatient and on --

DR. SUBODH JAIN: -- on the outpatient basis but

then they would not be able to take care -- like regular psychiatry unit do not have -- are not equipped to take care of those patients.

DR. MACALLISTER: Correct.

DR. SUBODH JAIN: So the med psychs units should be.

DR. MACALLISTER: And that's where I'm wondering with the acuity level if that might be the issue that conflicting with LARA in regards to some of the requirements by code to accommodate patients that are intubated and the like, if that would be part of the conflict. I'm not quite sure within LARA.

MR. WIRTH: I think the conflict is that these patients are needing to receive some treatments at the freestanding if I'm understanding correctly, but right now they aren't able to provide those treatments in a non-acute care hospital.

DR. MACALLISTER: Right. And that's where I'm thinking it's acuity level, but I'm not sure. So that, again, but it would be helpful to understand where the discrepancies are between those two. So thank you.

MS. GUIDO-ALLEN: Commissioner Guido-Allen. I think the acuity level is somewhat, but if a patient is adult or pediatric -- and correct me if I'm wrong -- if they require intensive care, a freestanding --

DR. MACALLISTER: You can't do that. Right.

MS. GUIDO-ALLEN: -- that would never even be in the picture.

DR. MACALLISTER: Right.

DR. SUBODH JAIN: Uh-huh; absolutely.

MS. GUIDO-ALLEN: And I think that at that point the medical care would outweigh the psychiatric care.

DR. MACALLISTER: Correct.

MS. GUIDO-ALLEN: And I think that's what we need some clarity around from the workgroup as well.

DR. MACALLISTER: Right. Yeah, I think that's exactly what I'm thinking about, yeah.

MR. FALAHEE: Other questions? Thanks for your education, Dr. Jain. Keep the March 16 date open on your calendar. I think you'll be back here again.

DR. SUBODH JAIN: Thank you. Thanks for having me.

MR. WIRTH: Next we have Dr. Deighton of McLaren.

KEN DEIGHTON

MR. KEN DEIGHTON: Morning. I'm Ken Deighton. I am not a doctor.

MR. WIRTH: Sorry.

MR. KEN DEIGHTON: My brother's a doctor, my father's a doctor. I am the solution lead for behavioral health for McLaren Health Care and I serve as director of

behavioral health services at McLaren Flint and McLaren Lapeer Region hospitals and with over 30 years experience working in Michigan hospitals with people requiring psychiatric treatment, I'm well aware of the daily challenges of access to services. And on behalf of McLaren, I participated in a number of the psychiatric services workgroups put forth by the CON Commission including the workgroup that brought about the recommendations for the special population beds and I appreciate the opportunity to address you today.

You should have in front of you a letter from McLaren's Chief Medical Officer, Justin Klamarus, on the issue of child and adolescent psych beds and I'll be speaking to his request today.

The CON Commission and the Department have been very thoughtful in their approach to addressing unmet needs for the provision of psychiatric services. This has been confirmed by this discussion this morning and on an ongoing commitment to making special population pool beds available and to forming these workgroups to address issues that have been raised by the provider community. However, the bed need methodology is not designed to nimbly address a paradigm shift in the provision of psychiatric services toward a continuum of care that includes more than just special population beds. Our state has reached a point of

dire need for access to general children inpatient beds across county lines, particularly in urban centers. To give you an example, just this month I shared a story of a 9-year-old child with severe psychiatric illness was brought to McLaren Oakland Emergency Department in Pontiac on January 3rd after an incident in her foster care facility and her outpatient psychiatrist recommended inpatient hospitalization. On January 9th, the hospital leadership staff contacted me at Flint begging for help. Is there something I can do? This prompted calls from me to my friends around the state and to the leadership staff at the community mental health services provider responsible for the authorization in service what can be done to get this child to an appropriate setting and was it appropriate to have her in an alternate setting? Despite numerous attempts to get her more appropriate setting than the ER, she was not admitted to an inpatient psych unit until January 17th. A two-week stay in the emergency department for a 9-year-old is simply not acceptable. Unfortunately, this is one of the many similar stories that exist.

Families, communities, hospitals are struggling with the safety concerns for kids that need help, and increased access to appropriate psychiatric beds through this proposal is a step in the right direction toward getting children out of the EDs and into proper psychiatric

care.

We recognize this is a multi-layer issue and there are many components that work together to address the needs. As such, we want to be part of the solution at every level starting with access. We'd like to work with the Commission and Department to lift the regulations on child and adolescent beds for a temporary period to allow providers to bring the necessary beds online. This temporary period would be mentioned -- and I appreciate my time is up here -- but I'm happy -- appreciate your consideration of this request and happy to answer any questions that you may have.

MR. FALAHEE: Questions from the Commission? Okay. I'll go. I talked to the folks at McLaren a number of times and as I understand the proposal -- tell me where I'm wrong. So to address the 9-year-old, what you're proposing is doing away with current language in the standards; right?

MR. KEN DEIGHTON: Correct.

MR. FALAHEE: To allow that 9-year-old, for example, to be admitted to a med psych unit?

MR. KEN DEIGHTON: No. Really what we're looking at is to open up the ability to, you know, still meet the licensing requirements for a psychiatric unit, but to put a temporary hold on the CON requirements for child/adolescent beds. I can tell you currently there are 11, only 11

licensed psychiatric units for child and adolescent in the state of Michigan plus the state operated facility in Northville at Hawthorn.

MR. FALAHEE: So when you say "temporary hold," help me understand. What do you mean by that?

MR. KEN DEIGHTON: Just in period -- in a period of review. So the three-year review to look at that to say, look, if there are facilities that -- hospital systems that are interested in providing the service, the need is such at this point that we're at to open it up so that we're able to meet that need and then obviously the CON was put into place for good reasons and so we want to, say, make it a temporary opening up for that.

MR. FALAHEE: So when you say "open it up" -- and I may turn it over -- yeah, okay. Tulika read my mind. Tulika, go ahead.

MS. BHATTACHARYA: Thanks, Chip. We have worked on a potential bill so we know a little bit about the background also.

MS. TURNER-BAILEY: Can you speak up just a little bit, Tulika? I can't hear.

MR. WIRTH: We can pull the microphone closer.

MS. BHATTACHARYA: Oh, sorry. We worked on a potential bill on this same issue so we know a little bit of the background. So what he is basically requesting is to

put on hold the bed need methodology for child/adolescent beds and so the applicants will still need to apply for a CON, go through that review process, agree to abide by the project delivery requirements and you can put a time frame for how long this exception or exemption will be in place, three years, five years. But right now what is happening if a hospital or an entity is capable of setting up child/adolescent program, they can't because there are no beds available.

So when we look at the child bed situation, there are 27 beds available in HSA 3; seven beds in HSA 5; and 15 in HSA 7 and three in HSA 8. But in HSA 1 or 2 or 4, you know, the other ones, there are no beds available.

MR. FALAHEE: And even if there are beds available, it sounds like for this 9-year-old there weren't any beds available?

MR. KEN DEIGHTON: That's correct. We eventually found one. It was -- it was, you know, of those 11 licensed psychiatric units that are currently operational. We're not worried about county lines in this situation. We're getting to the appropriate place. Who can take care of this young girl and how can we get them to that place? So we're really looking at the bed methodology and the HSA regions.

MR. FALAHEE: So this is related to that bill that was introduced last fall that never was formalized and

approved by the legislature? Is that similar to that?

MS. NAGEL: That one, it was a little different. It completely deregulated child/adolescent beds from CON. And so the Department thought that perhaps through the CON process we could do something with a little more fidelity that might meet, you know, the goals of the kids who need these beds.

MR. FALAHEE: Okay. And then more -- more CON speak, not so much for your answer, but for the Department. Would the thought be if the Commission looked kindly on this request to make that part of the psych workgroup?

MS. NAGEL: I think so, yes.

MR. FALAHEE: Okay. I'm just making sure. Would we need to add a charge to the workgroup to do that?

MR. WIRTH: Yes.

MR. FALAHEE: Okay. So make a note that we need to do that so when we make a motion eventually we make sure to include that. All right. So what you're asking for and what Tulika and Beth have explained is trying to get a need met for the 9-year-olds, the 6-year-olds or whatever so they're not sitting in a ED for 16, 19 days? That's the bottom line?

MR. KEN DEIGHTON: Yeah. And we would like it to stay at the Commission level. You know, I participated in the workgroups, great work occurs in there, but it does slow

down the process considerably.

MR. FALAHEE: Yeah. And this proposed solution would be still keep the project delivery requirements in place so that there still is CON oversight and control over it so it's not totally carte blanche do whatever you want?

MR. KEN DEIGHTON: Correct.

MR. FALAHEE: Okay. All right.

DR. MCKENZIE: This is Commissioner McKenzie. I have another question related to that. I think it's an interesting proposal and, you know, I'll just make a comment as well. We are seeing this in our data at Blue Cross, that there are significantly more children waiting than adults and the lengths of time are greater and so we're very concerned as well. I do want to ask because I have heard this. If we were to take this action, is it your opinion or from the discussions that you had that facilities have the ability to respond and bring some additional beds online? Because there are also staffing issues and does that compromise ratios or anything else and is that imbedded within the standards or anywhere else that we also need to consider from a quality and care standpoint.

MR. KEN DEIGHTON: Yeah, the -- the -- as I mentioned in my comments, this is just one of the factors that contribute to the problem of finding appropriate places including the lack of staffing, the challenge in recruiting

psychiatrists and that specialty child/adolescent psychiatrist. These are all things that contribute to that. So we're not saying this is a cure-all, but we are saying it's a step in the right direction.

DR. MCKENZIE: Okay. Thank you.

MR. KEN DEIGHTON: Thank you.

MR. FALAHEE: Other questions?

MS. GUIDO-ALLEN: Guido-Allen. I have a -- I have a question for Tulika. Is there not a mechanism in place now regardless of if the methodology shows an area as over bedded for child and adolescent psych beds that they can work with the Department to get more beds available?

MS. BHATTACHARYA: Yes. So there is a provision in the standard for existing hospitals to add beds under high occupancy if they can demonstrate they're operating at -- I can't remember the exact numbers -- 70 or 80 percent. So that is for existing providers to add more beds.

MS. GUIDO-ALLEN: But not for new?

MS. BHATTACHARYA: Not for new providers to start a new facility. However -- and, sorry, Kenny, is that proposed language going through that process?

MR. WIRTH: It is.

MS. BRADSHAW: We changed, revised the set standards to add more beds outside of the bed need

methodology based on ED waiting and ED holds. Would you please share that, please?

MR. WIRTH: Yeah. We added language that's working its way through the process right now to allow a hospital able to demonstrate that they have a patient in their review (inaudible) for a certain amount of time. If they can demonstrate that, then they're able to open a ten bed psych unit, I believe, was the language.

MR. FALAHEE: Commissioner Ferguson?

DR. FERGUSON: So I'll start with a question to you is how much -- I'm trying to respect however you want to run this. You want me to hold comments, discussion 'til the end and stick with questions or do you want me to make a comment about this? I'm trying to figure out when we're having the discussion and when we're having --

MR. FALAHEE: I'm open to anything at this time because I think --

DR. FERGUSON: All right. That's fine.

MR. FALAHEE: -- if you have comments or questions, I think it all helps us --

DR. FERGUSON: That's fine. I just didn't know how you're trying to gauge because I know we've had a couple of different approaches. So generically I think we have a serious issue with access and I think that we need to solve it and we need to solve it quickly, both med psych, adult,

children, the whole kit and caboodle. We've heard, you know, on and on both within the confines of this, within our professional lives, within our personal lives, within the media we got a serious problem. I guess my ask of the Department is help us get there and help us get there very, very quickly. Right? I think we need solutions that aren't two, three years down the road. I think we need to be able to move. With respect to flat-out waiving, temporary waiving the bed count cap -- and I say this with caution -- I have some apprehension about a temporary waive on that in the sense that -- I want to make sure that we don't show -- we need to solve the problem quickly. I want to make sure that we're not feeding into only those facilities that actually have a building that already has, you know, rooms that can be immediately converted, get a temporary windfall because actually planning facilities takes years. And so I don't know what the answer is on this and I'm going to defer largely to the Department, but I'm going to make a really strong plea that we need to really move on this and we need to move quickly and it needs to be comprehensive. It can't just be one little corner of psych care, one little corner of psych care. We got a problem across the board.

MR. WIRTH: So my response would be that we are waiting for these review standards to go through the legislative process. We have a statutory requirement that

there's a 45-day review period and we need nine legislative session days within that period. We can't skip that. That's within statute.

DR. FERGUSON: Yeah. That's fine.

MR. WIRTH: So right now we've had two legislative session days -- four? -- three -- four, sorry. We've had four legislative session days for those standards. So sometime in the spring those will become effective. We can't speed that process up --

DR. FERGUSON: Will that solve all of this? I mean, did we -- frankly did we revise and loosen enough to actually accomplish what we need to accomplish which is to serve the mental health needs of our state?

MR. WIRTH: The Commission approved language to provide what we spoke of as a steam release for this to allow, you know, the ED to demonstrate that they can't place patients. I can't speak to whether that will solve the entire problem. But if we are to go through this process with a workgroup, we'd still be facing our statutory requirement of going through our public hearings and --

DR. FERGUSON: I'm not opposed to the public hearings. What I'm trying to do is to get -- I guess I'm making a plea for something more than incremental change. I'm asking for wholesale change because I think we have a crisis.

MR. FALAHEE: And I think -- yeah, I think the advantage of this workgroup is it's doing that. We've got the right people on it and assuming we amend the charge to account for the fact that, as we all know, there are major issues out there right now. I think that workgroup could address your needs.

DR. FERGUSON: All right.

MR. FALAHEE: Let's get on it. Let's try to fix it in one fell swoop. And we've got some language in there already. We're just waiting for the necessary legislative days. But that is not a complete fix. And giving a facility the go-ahead to say, oh, you can put in ten psych rooms for kiddos, as one that works with four acute care hospitals and I know Commissioner Guido-Allen, same thing, it is not easy to set up a psych unit in the middle of what's now a general acute care unit. There are all sorts of ligature requirements, what the doors look like, what the door handles look like, you know.

MS. GUIDO-ALLEN: Ceiling tiles.

MR. FALAHEE: Just because you can do it, oh, my gosh, it's next to impossible.

MS. GUIDO-ALLEN: Yeah.

MR. FALAHEE: It helps, but it's not the solution by any means. Any other --

DR. MACALLISTER: So Commissioner Macallister.

I'm thinking as you're talking and just specifically what you had mentioned in regards to the requirements on the physical environment side as well and looking through the definitions of what we have in Section 33320.100, is that maybe what we have to do is actually define it as a separate entity itself. So we have the freestanding, you know, we have -- we have the ambulatory facility defined, we have long-term care, we have all of these. I'm wondering if it makes more sense to have a full definition of psychiatric. There's no mention. I think it's being rolled into ambulatory or acute as opposed to being pulled out into a clean, clear definition that's written in our standards for what deems psychiatric or behavioral health beds as a separate autonomous definition within our jurisdiction so then that can then tie back to some of these other domains. It seems to be lumped in to kind of the general, acute, long-term, ambulatory as opposed to its own independent. So I'm thinking that may be part of what the SAC or the workgroup is defining and maybe that would help.

MR. FALAHEE: I would think -- this is Falahee again -- that the workgroup as it's looking at how to define those terms if it saw a need to do that. To me that's part of their definitional charge, if you will, to make that.

DR. MACALLISTER: Got it, yeah.

MR. FALAHEE: Good point. So those on the

workgroup, at least I think you've got that permission, that authority under that charge to do that if that's helpful. Other questions for Mr. Deighton? You've been very patient and helpful with your comments. Thank you. Thanks a lot.

MR. KEN DEIGHTON: Thank you so much for your time.

MR. WIRTH: Next we have Jennifer Nyhuis of UHS.

JENNIFER NYHUIS

MS. JENNIFER NYHUIS: Hi, good morning, Chair, Vice Chair, Commission. Thank you so much for the opportunity to speak. My name is Jennifer Nyhuis. I am the group CEO for UHS facilities here in Michigan and glad to be here today.

So a couple of things I wanted to share in relation to the conversation. And, Kenny, thank you for that wonderful introduction of a very complex situation we have. One thing I wanted to start with is we feel that in order to meaningfully revise the med psych requirements for freestanding hospitals, the informal workgroup's charge needs to be expanded past just looking at the definition, but also to revising the substantive provisions of the addendum to the standards, that which includes the requirements for the actual specialty pool beds. In addition, because the same set of substantive requirements in the CON review standards apply to all med psych beds as

we just discussed including both freestanding, acute care, adult/pediatric, we think the Department should combine both workgroups into the informal workgroup established, review the freestanding requirements as well so we don't end up on parallel tracks working on overlapping issues. And lastly, we think it's important for the integrity of the system that all substantive changes to the standards be made via the informal workgroup as I know we've had some discussions about today or the SAC committee process with the opportunity for public input. Otherwise, I do feel and we believe that we risk undermining the integrity over all of the CON rulemaking process.

So I appreciate your time and just to wrap up, I really -- it's important that we look past just that definition, really look at some of the provisions, combine those two -- those two groups to kind of make sure we're looking at this as a whole complex issue as we've discussed because there are many factors involved like we've talked about. And the need is great, absolutely, but there's so much -- so much to look at here and there's so much beyond, I think, just like as I think was mentioned one simple solution. There's many. And I think we can do it with the informal workgroup process. We have some wonderful advocates here in Michigan as I've gotten to know the last couple of years being here and I am very fortunate and

grateful to be here and be a part of this process. So thank you so much.

MR. FALAHEE: Great. Thank you very much. Thank you for being here. Questions? So I have one. When you say "both workgroups," to me there's one workgroup and then something that the Department is working on. Is that --

MS. JENNIFER NYHUIS: So, yeah. So my thought on that is actually just ensuring that we don't have a separate workgroup for the freestanding and for the acute.

MR. FALAHEE: Yeah.

MS. JENNIFER NYHUIS: That is a combi- -- thank you to clarify. Yes, that's a combined workgroup because as we've mentioned, you know, we don't want parallel tracks. We don't -- it is, you know, one set of specialty pool beds of course, yes, different implications. But I do feel that the best way to address those is within one workgroup so that we can separate if there's individual needs of both.

MR. FALAHEE: Okay. And looking at the Department, would that request -- should the Commission go for it -- require a change or an added charge?

MR. WIRTH: Yeah. That would require the Commission to add the acute care onto the charge for the med psych workgroup, yes.

MS. JENNIFER NYHUIS: Correct. That was the request. Thank you. Yeah.

MR. WIRTH: Yeah. So many different --

MS. JENNIFER NYHUIS: I know.

MR. WIRTH: -- aspects, avenues. So thank you.

MS. JENNIFER NYHUIS: Right. Thank you.

MR. FALAHEE: So Falahee again. Don't leave yet.

MS. JENNIFER NYHUIS: I'm here.

MR. FALAHEE: Thank you. Keeping score, is that the third potential added charge to the workgroup?

MR. WIRTH: It would make three total charges, I believe.

MR. FALAHEE: Added? Added charges?

MR. WIRTH: Well, there were two added today.

MR. FALAHEE: Right.

MR. WIRTH: Including this one.

MR. FALAHEE: Okay.

MR. WIRTH: And then there was one on the workgroup already.

MR. FALAHEE: All right. Get ready for at least this chair to -- on behalf of the Commission that once we hear from all of our public commenters to summarize what we would need to do as a Commission. Okay? Just predicting the future.

MS. JENNIFER NYHUIS: Keep them busy.

MR. FALAHEE: All right. Other questions? Thank you very much. Thanks for being here.

MS. JENNIFER NYHUIS: Thank you so much. I appreciate it.

MR. WIRTH: Next we have Sean Gehle from Trinity.

SEAN GEHLE

MR. SEAN GEHLE: Good morning, Mr. Chairman and members of the Commission. Thank you for the opportunity to address the informal workgroup and the conversations that we've been part of. I'm Sean Gehle. I serve as the advocacy leader for Trinity Health Michigan. On behalf of Trinity Health Michigan, I want to thank Dr. Jain and the Department for the conversations that we've been part of. I think we've made significant progress around the med psych unit definition in an acute care hospital. Appreciate Dr. Jain's leadership and the Department's leadership in coming to some consensus. We're not quite there yet, but I think we've shown significant progress and we're very encouraged that we'll have some consensus soon on that issue.

On the freestanding issue, I don't want to duplicate what's already been said, but given the conversation that you've had as a Commission, we would also ask for the latitude within the conversations that are currently ongoing to discuss the issue of freestanding psych facilities, the current conflict that exists with LARA and DHHS, and the acuity level that freestanding psych facilities are admitting patients and whether it's

appropriate to access med psych -- that med psych pool of beds or what can be done already within freestanding psych facilities to provide a minimum level of medical care for patients being admitted to those freestanding sites.

So I have a definition -- or I have some language that I'd like to offer to the Department that would expand the latitude of that workgroup charge to allow for a more robust discussion of the issue of freestanding psych facilities and the appropriateness of the med psych pool of beds to be accessed by those facilities. So if I can hand that to the Department and just ask for your consideration in doing that? And I'm happy to answer questions, but I didn't want to duplicate the previous speaker, so --

MR. FALAHEE: Thank you, Mr. Gehle. Questions?

MR. SEAN GEHLE: Thank you.

MR. FALAHEE: So I'll -- I'll -- don't -- sorry, Sean. You don't leave unscathed. Can we hear what you've proposed? Because I -- as I understand it, Sean, before you read it, is it trying to address what can be done within a freestanding facility absent tapping into the med psych pool of beds?

MR. SEAN GEHLE: It is intended to discuss that.

MR. FALAHEE: Okay. All right.

MR. SEAN GEHLE: And my understanding is that prior to a change in language several years ago that

provided for freestanding psych facilities to access the med psych pool of beds which has now caused the conflict between the two departments, that these beds were originally intended -- and please correct me if I'm wrong -- intended to address those patients who had acute medical issues and also had a psychiatric diagnosis and it was to provide for units within acute care hospitals primarily to treat -- to have that special pool of beds. I understand there was some discussion subsequent to that original purpose that provided, that allowed for freestandings to have some type of collaborative agreement within an acute care facility. We would just like the latitude within the workgroup to review that whole discussion more thoroughly and get at the issue that many of you have raised about the acuity level of those patients that are admitted at psych facil- -- freestanding psych facilities. So the language that we are suggesting would just say,

> "Review modifications to Sections 1(4), (3), (6) and (9) of the addendum for special population groups to allow and specify requirements for freestanding med psych units and medical psychiatric units as units of acute care hospitals."

We think that provides the latitude to have that discussion. When Dr. Jain and the group discussed this in the past, I believe, Dr. Jain, we felt -- you felt and

others that it was beyond the scope of the current charge to have a conversation that got into the original purpose and therefore we're asking that there be that latitude within the charge.

MR. FALAHEE: Okay. Great. Questions? Thank you, Mr. Gehle. Appreciate it.

MR. SEAN GEHLE: Thank you very much.

MR. FALAHEE: And, Kenny, since I'm keeping score, would that be yet another add on?

MR. WIRTH: I think so. It kind of meshes with an earlier request, just to kind of expand the scope, so --

MR. FALAHEE: Okay. Okay. Well, rather be safe than -- to Commissioner Ferguson's point, I'd rather get language out there that lets that subgroup look at that, workgroup look at whatever there is and wave several magic wands to see what they can come up with as a quick fix.

MR. WIRTH: That's all the blue cards I have.

MR. FALAHEE: Okay. Thank you. That's all the public comment. Now it's time for Commission discussion. We've obviously had a good discussion already. Is there anything that the Commissioners would like to discuss based on the comments we've heard so far?

DR. MACALLISTER: Can we actually repeat what we have now so we can just make sure we understand what you're --

MR. FALAHEE: That's one of the reasons I was keeping score, if you will.

DR. MACALLISTER: -- yeah; yeah. But I think it would be helpful to hear it again just to make sure.

MR. FALAHEE: Right. Nope. Not a problem. Kenny can we put you on the spot, please, as you're scribbling?

MR. WIRTH: Trying. Trying to keep it legible for myself. So I believe the requests that we have on the table: so there's an existing charge for the psychiatric beds and services workgroup. That existing charge is to explore a definition for a freestanding medical psychiatric unit to facilitate that possibility. Today we've heard -- and, Chip, I think you're right about there being three additional. I kinda of went back through and figured that out. We have an addition of acute care (inaudible) charge, to explore that, expanding the scope of the workgroup further into the addendum and I believe Sean just mentioned Sections (3), (6), and (9) being added onto that charge. And then there was also the request for a temporary hold on the use of the child and adolescent bed need methodology while still maintaining project delivery requirements (inaudible) part of that.

DR. MCKENZIE: Commissioner McKenzie. Can I clarify on the addendum that was added by Trinity? Does that mesh with defining the difference of what a

freestanding versus an acute hospital can tap into from a med psych? Have I understood that correctly? From, like, the med psych beds while also potentially offering any additional relief valve that the freestanding can tap into without tapping in the med psych?

MR. WIRTH: We can make that part of the charge, yes.

MR. FALAHEE: I'd rather it be, like I said -- to Commissioner McKenzie's point, I'd rather make sure we open it up enough so that they don't come back in March and go, "oh, you put restrictions on us. Please do away with those."

MR. WIRTH: Yup. No, we can make that flexibility with the charge.

MR. FALAHEE: Commissioner Ferguson?

DR. FERGUSON: Yeah, along those same lines I would ask that whatever language ultimately gets proposed with respect to the adult and child bed availability and the concept of is there a temporary waiver or not, I would ask that we give the workgroup latitude to explore alternative solutions to the need and not simply that's the only proposal that they can consider.

MR. FALAHEE: Good idea. Thank you. I'm tempted to semi-facetiously to add a final charge that says "workgroup, come up with anything else you think might work

and present it to us."

DR. FERGUSON: That was my comment earlier essentially; right? Solve it.

MR. FALAHEE: Yeah.

MS. GUIDO-ALLEN: "And other duties as assigned."

MR. FALAHEE: Right. I think we're not the experts as we sit around this table. Let those within the workgroup do that and maybe that -- we'll call it our wild card charge. But if they see something that would solve this or help solve it, far be it for us to get in the way of that.

MS. GUIDO-ALLEN: Agree.

MR. HANEY: Would that be the only -- sorry. Commissioner Haney. Would that be the only addition change because then you can --

MR. FALAHEE: No; no. I think we need to be specific. There's got to be some order here. So I think we've -- we list -- what we've heard so far based on public comments, we've recognized these three or four issues that Kenny summarized need to be addressed in terms of a modified charge or an added charge, and then I think we can add the wild card charge I call it as a final so that we have a workgroup that knows we can do whatever we think is going to work to solve this acute problem for behavioral health. As any of us in health care, any of us that have relatives in

that position, we know what's going on and it's awful. Any other discussion?

DR. MACALLISTER: Commissioner Falahee?

MR. FALAHEE: Yeah.

DR. MACALLISTER: Commission Macallister. I still feel like there's a need in regards to even within the definitions of the health facilities of agency that we're demonstrating. Like there's the medical care facility, the freestanding surgical facility, the mainten- -- you know, the facility, maintenance facility, age, hospital, nursing home, hospice, hospice residence. It doesn't have behavioral health as a pullout line item and I think that if we had that clarification of behavioral health because we even have crisis stabilization units that are coming into play for emergency. I mean, I think that there is varying components of its own designation within what a health facility or agency is for behavioral and mental health, but I feel like if it had its own kind of line and domain, clarification, that it would help to kind of assimilate and not continue to try to be put into each one of these other buckets and underlying and really allowing that to be its own entity.

MR. WIRTH: Dr. Macallister, is that within Part 333201?

DR. MACALLISTER: Uh-huh (affirmative).

MR. WIRTH: That's not something the Commission can change. That would require legislative action.

DR. MACALLISTER: Right. But I -- I understand that, but I'm just wondering if that would -- if we could -- I don't know if there's even an opportunity to propose that as a potential within --

MR. WIRTH: I would look further down the table --

DR. MACALLISTER: Beth?

MR. WIRTH: -- to Beth on what we can do legislatively.

MS. NAGEL: I think that we'd need to look into it a little bit further to be honest.

DR. MACALLISTER: Yeah. I think that's what's muddling it to be honest in regards to the fact that we're trying to fit a behavioral health which is its own kind of identified body of people into various different modalities.

MS. NAGEL: Yeah, I'm not -- you know, I'm not sure on that. I think we should wait and see what the workgroup comes up with because I think that there are some proposed solutions that don't require statutory changes that may meet the same goal.

DR. MACALLISTER: Correct; yeah.

MR. FALAHEE: And that -- this is Falahee. That's where I'd be. I think as part of the wild card charge, if the workgroup thinks those definitions are getting in the

way, let us know and we can do our best to let that be known to the legislature and say here's part of the problem. Okay?

DR. MACALLISTER: Problem, right.

MR. FALAHEE: But I think let's see what they can come up with. And then with the wild card charge as I call it, give them the ability to do that.

DR. MACALLISTER: Okay.

MR. FALAHEE: But thank you for pointing that out. As soon as you said 333 I went "oh, nuts." That's not within our purview.

DR. MACALLISTER: Right.

MR. FALAHEE: But we can -- we can make suggestions. Okay. Other discussion? Very good discussion. Okay.

MS. TURNER-BAILEY: So I have a ques- -- quick question. Commissioner Turner-Bailey. I'm just wondering are we -- is this -- are we trying to fix the issue that Tulika brought up earlier with regards to the HSAs that have no beds or if this is a broad -- we need to fix this problem across the board?

MR. FALAHEE: This is my comment and no, Tulika will correct me. I think we're doing everything we can to fix the problem across the board and we're saying to the workgroup through amending charges, adding charges, and then

adding the "wild card" charge in quotes, if you see something that can fix the problem we have, please recommend it to the Commission. That's how I look at it. Now, if others disagree, please let me know. Tulika, any comments about that?

MS. BHATTACHARYA: No.

MR. FALAHEE: Okay. Thank you.

MS. TURNER-BAILEY: Thank you.

MR. FALAHEE: Good question. Thank you. Other discussion? Normally at this moment I'd look for a motion or I'd say it and then entertain it, but I will turf it to Kenny to summarize what it is we would need to do to amend current charges, add new charges, and as a final one add the what I euphemistically call the wild card charge.

MR. WIRTH: So I -- first I'd like a little more guidance on what exactly we're looking at this wild card charge to do because are we opening the entire standard for any revisions in line with what the wild card charges will be to accomplish or are we keeping a narrower scope on --

MR. FALAHEE: To me -- to me we're trying to fix a large, large problem and to me -- I'm just one of 11, right -- I think the wild card charge would say open up anything related to psych and workgroup, if you have recommendations, please submit it to the Commission. Now if that makes the Department wince, please let me know. I'm

sorry. I'm just trying -- you know, in health care we're driven by, you know, what's best for the patient. We've got a lot going on now that's not best for the patient within quality, access and cost.

MS. NAGEL: I think it may -- I will say this I think it may make us wince because it is something we've never had before. We've never had a wild card charge. And, however, to your point, this may be one time that the issue warrants a wild card charge. So I think that we will be okay with it and bring back to you something that -- we hold the same goal, to fix the problem, so --

MR. FALAHEE: Having had the pleasure of working with all of you on the other side here, I know we all hold the same goal and everybody around this table does and we know we've got a huge problem. As our witnesses have said, as we all know that are in acute care and any field of medical care it's a problem out there. In Bronson's case, we ended up transferring a kid to Montana. That's not good.

DR. FERGUSON: So I agree with you completely that we need to be very open-ended in the offerings. If it's helpful to the Department and the process here, as we go in the wild card zone, if there's need for some dialogue back and forth or some of the things we're thinking about might be -- you know, funneling that back and forth and having a dialogue may be helpful so that we don't find ourselves way

down some weird rabbit hole that we don't want to go to if that's of greater comfort to the Department. I'm fine with the wide open charge. I mean, you heard me before. I mean, I'm all in. But if that's overwhelming to the Department and you want to have a -- if stuff is kind of in this wild card zone and you want to have some dialogue at our next meeting here we can do that. I'm open to whatever gets us to the end.

MR. FALAHEE: Yeah, I think -- yeah, to, if you will, put some --

MS. TURNER-BAILEY: Guardrails.

MR. FALAHEE: -- guardrails on the workgroup to say in your wild card, if you're coming up with something and you go "oh, my gosh, don't know if we can even do this" or the Department goes "you can't do that, here's why," I think we can have that interactive process so and it can occur in between Commission meetings as well.

MR. WIRTH: Two quick things. I think one of the reasons that we'd like some more guardrails around this workgroup is just that we haven't entered our conversation with the special Commission meeting yet so we still have multiple other workgroups and SACs that we'll hoping to start this year on top of continuing the psych beds workgroup. And I'd look back at the original charge for the psych beds workgroup in September of 2021. One of the

charges on there was to consider creative ideas for improving access to child and adolescent psychiatric beds. So I wanted to put that out as an option for some type of a wild card. I don't know if you want to expand it past just child and adolescent or not, but that was the language that was on the previous charge so if we can do that again to give us some --

DR. MCKENZIE: This is Commissioner McKenzie. And I was actually thinking about that exact charge of, like, maybe the guardrails you put on it are any solutions that will improve access or, you know, identify, you know, barriers that are limiting access, you know, within the state to psychiatric care. And I think it could be restricted to child/adolescent, but it probably could be opened actually at this point to adult. That would be my preference.

DR. FERGUSON: It should be open to all --

MR. FALAHEE: Right.

DR. MCKENZIE: I think it should be opened to all, so --

MR. FALAHEE: Here's -- yes. This is Commissioner Falahee. And I've got some proposed language in front of me thanks to Brien and the Department, you know, and being the lawyer myself, sometimes lawyers can be helpful. All right. So the potential wild card, when you say something like, to

the workgroup, "you have latitude to identify ancillary issues and potential solutions related to child, adolescent and adult psychiatric services," something like that. And I think working with the Department and the workgroup together, to Commissioner Ferguson's point, you come up with a wild idea, let's make sure it's potentially doable and not something that we know we or the Department knows we can't do or LARA, for example. Okay. I'll turn it back to you.

MS. TURNER-BAILEY: I -- I have a --

MR. FALAHEE: Sorry.

MS. TURNER-BAILEY: -- I have my hand up.

MR. FALAHEE: Oh, sorry. That's all right. Sorry. Commissioner Turner-Bailey?

MS. TURNER-BAILEY: Okay. Commissioner Turner-Bailey. I certainly understand and hear the critical nature of the problem that we're trying to deal with here. Last year at some point we made a decision about workgroup sort of, you know, hey, we need a new charge and just calling you up and saying, you know, we need a new -- you know, we need a new charge and we decided that wasn't the way we wanted to operate those workgroups. That we wanted those charges to come back to the Commission to be considered. Maybe one of the things that we can do here today in lieu of a "wild card charge" which I am personally not all that comfortable with, is allow that kind of

interaction just this once for this workgroup so if they come up with something that needs to be considered and they think might need to be added to the charge, that they could do a direct communication with the chair or with the chair and the vice chair, however we decide to handle it, and allow that to happen as an exception for this workgroup.

DR. FERGUSON: Chip, can I --

MR. FALAHEE: The reason I'm asking -- I understand your points exactly. I think we all understand the merit of a wild card charge here, but we don't want the wildness to just -- to pervade throughout any workgroup or SAC.

MS. TURNER-BAILEY: I'm sorry. Just as a comment. I realize we're all, like, what -- what should we do? You know, something needs to happen. We need to do something quickly. But I also sort of feel like people have been thinking about this issue for quite some time. So I'm -- I'm not all that confident that, you know, the miracle answer is going to come out of this workgroup. I don't know. Maybe it will. But I -- but I do -- but I'm not comfortable with sort of just, you know, go do whatever you think you should do.

DR. FERGUSON: I guess I would ask, though, that whatever charge we give them is not a "if you happen to want to put forward some alternative idea you can." I would ask

that the charge specifically include -- if not the wild card, specifically include "please consider other solutions to access for adults and children." All right? So if we want to narrow it, that's fine. But I don't -- I'd like it to not be an after thought in terms of -- if you have an after thought additional proposal, bring it forward. I would actually like it to be part of their charge which is go think creatively. And we may not find the miracle cure. I get it. But we do have a serious problem and we ought to at least explicitly charge them to try and come up with that creative solution.

MR. FALAHEE: Okay. Other comments?

MS. GUIDO-ALLEN: Commissioner Guido-Allen.

MR. FALAHEE: Yeah.

MS. GUIDO-ALLEN: We've been -- I think that there's been an informal workgroup or SAC since I started on the Commission for psychiatric and we're no better off than we were back then. So I think that allowing the experts, the subject matter experts, to be able to provide us with ideas and solutions that are not restricted, you know, are still legal -- don't get me wrong -- that we should allow them to bring forward what will make this better for the communities that we serve.

MR. FALAHEE: Thank you. Other discussion? Good discussion. Thank you. Kenny, you want to summarize what

we would need to do? I know it's a tough task, but --

MR. WIRTH: I'll do my best.

MR. FALAHEE: Okay. Do you want to take all of these as one as a potential motion? Let's say there's four items that Kenny will present. We can all listen and then somebody could make a motion, we could take them all together or we could do one by one by one. We'll do them all at once. Okay.

MR. WIRTH: Okay. And so I think part of this motion would be to direct the chair to write the charge based on this discussion today and select the chairperson and vice chairperson if you would like to select a vice chair. So the additional charges that would be added today from this conversation would be to explore the acute care med psych issue, it would be to --

MR. FALAHEE: What do you mean by "explore the acute care med psych" --

MR. WIRTH: Well, it would be to correct the problem that we're experiencing currently. There's this second group that has been working outside of the workgroup process. Bring that into the workgroup.

DR. MACALLISTER: So merge --

MR. FALAHEE: I'm being real picky here.

MR. WIRTH: I know.

MR. FALAHEE: You're ten miles ahead of me because

you're so deep into it. I'm just trying to make sure I have something for the record.

MR. WIRTH: There's one workgroup happening right now and there's an external stakeholder group that has been trying to address an issue with the acute care side of the med psych now. We will bring that external group into the workgroup, essentially combining the two groups, so one workgroup. We'd also expand the scope of the workgroup to explore flexibility with freestanding which is what was discussed with UHS and Mr. Gehle. We'd also do a temporary hold on the child and adolescent bed need while still maintaining the project delivery requirements.

MR. FALAHEE: We wouldn't do the temporary hold. We would charge the workgroup to look at the issue of whether it's feasible and wise to do it --

MR. WIRTH: Correct.

MR. FALAHEE: Okay. Thank you.

MR. WIRTH: Correct. And then we would also explore alternative solutions to address the need of the psych bed crisis, that wild card charge which I think we were going to do similar to the 2021 charge; correct?

DR. MCKENZIE: I believe so, but expanding -- expanding to include adult.

MR. WIRTH: Yes.

DR. MCKENZIE: So and I would propose actually

using the language that was written.

MR. WIRTH: Yup. Which was giving the workgroup the latitude to identify ancillary issues and potential solutions related to psych services.

DR. MCKENZIE: Yeah. This is Commissioner McKenzie. I'd like to go back to charge two that you just explained again. And I'm sorry to keep pushing on this, but --

MR. WIRTH: Yup.

DR. MCKENZIE: -- but I want to make sure that that charge or an existing charge is also dealing with the ability of or the definitions around freestanding versus acute care and what they're able to tap into from a med psych. So there's two pieces to that. There's what flexibility exists for freestanding, but then also this definition between acute care and freestanding and what needs to happen from a med psych definition standpoint. And we probably need to, I know, beef -- buff up the language around that, but I just want to make sure that both of those pieces are captured unless we need a separate charge for them. I don't think we do, but --

MR. FALAHEE: No, I don't think we do.

DR. MACALLISTER: Chairman, just real quick. Do we also need to add the LARA component that there was some discrepancy between the LARA regulations?

MR. WIRTH: I think that will be captured with the acute care and the freestanding. That's --

DR. MCKENZIE: I think that's captured in --

DR. MACALLISTER: It's captured. Okay.

MR. FALAHEE: Okay. So if we were to consider a motion, it would be what you summarized just now with potential delegation of the formal charge to the chair and the vice chair of the Commission --

MR. WIRTH: Yes.

MR. FALAHEE: -- to work with the Department to come up with those formal charges; right?

MR. WIRTH: Yes.

MR. FALAHEE: Okay. I'm making sure I've got nodding heads on the other side of the table before we consider a motion. All right. Okay. Any discussion? Any questions of Kenny? Okay. You're shaking your head. Do you have anything else to add?

MR. WIRTH: Nope, nothing to add.

MR. FALAHEE: Okay. I would entertain a motion to basically move to what Kenny just said as it was friendly amended by Commissioner McKenzie.

MS. GUIDO-ALLEN: Commissioner Guido-Allen. As long as I don't have to repeat all of it, motion to do what Kenny said, amended by Dr. McKenzie.

MR. FALAHEE: Thank you. Is there support for

that motion?

DR. KONDUR: Commissioner Kondur. Second and support.

MR. FALAHEE: Thank you. Okay. We have a motion that's been out there and supported. All in favor of the motion please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: All opposed raise your hand? Okay. That motion carries.

(Whereupon motion passed at 10:51 a.m.)

MR. FALAHEE: Well that was our one agenda item. That only took -- what? -- an hour and a half. So there. I can't see how many bagels and brownies are left, but we'll -- you know. This often happens at the January meeting, I'm telling you, because we have substantive topics to discuss and as you in the audience heard, if you're here for other issues, we dive into it and the psych issue is huge. So there aren't easy answers and there's a lot of other important ones. What I'm planning on doing is going to the next one, the cardiac cath, to see how long that takes. We may take a break after that and then we'll come back and do Hospital Beds, MRT and the others on the agenda. Okay? All right. Kenny, anything else on that topic that we just concluded?

MR. WIRTH: No.

MR. FALAHEE: All right. Cardiac Cath, do you want to summarize where we're at on that, please?

MR. WIRTH: Yes. So public comment period was held from October 7th through October 21st of 2022. We received testimony from seven organizations. Summary of these as well as the comment letters are in the electronic binder. All testimony received was in support of continued regulation of Cardiac Catheterization Services. Department supports continued regulation of Cardiac Cath Services and is recommending that a Standard Advisory Committee be formed to take a look at some of the items brought forward. These include considering -- sorry -- considering provisions to improve access to cardiac cath services in rural areas including initiation requirements for elective PCI, consider adding the definition for STEMI to Section 2, revise the standard to list basic steps and application and notification requirements for discontinuing open heart surgery services and therapeutic cardiac cath services and other technical edits by the Department if needed. The Department is also recommending the technical edit cross all standards that would update the project delivery requirements --

(Off the record interruption)

MR. WIRTH: -- so we're also recommending the technical edit across all standards that would update the

project delivery requirements to require notification to the Department of any decrease or discontinuation in covered services at least 30 days prior to planned decrease or discontinuation of services. If a Standard Advisory Committee is to be seated, then a written charge will need to be drafted and voted on by the Commission or the Commission may instruct the chair to write the charge consistent with the language presented at today's meeting. The term of the SAC would expire six months from the first meeting of the SAC unless the Commission specifies an earlier date and the Commission chairperson would appoint the SAC members consistent with the statutory requirements and the CON Commission bylaws. The chairperson would also appoint the chairperson of the SAC. After the SAC concludes its work, the chairperson would then bring the SAC's recommendations to the Commission at a future meeting.

MR. FALAHEE: Thank you, Kenny. Any questions about that explanation of where we're at? Okay. Great. Then we'll open it up to public comment, please.

MR. WIRTH: Yes. Sorry. Trying to get situated.

MR. FALAHEE: That's all right.

MR. WIRTH: Cardiac Cath, first we have Eric Barnaby from Ascension.

ERIC BARNABY

MR. ERIC BARNABY: Thank you for allowing me to

make a couple comments. Eric Barnaby in charge of cardiovascular services, administrative partner for Ascension Michigan.

We're glad that the SAC is being recommended by the Department. What we would like to recommend is that we could include some of the other comments that were put forth and using the most recent SCAI document which will be released this month. The one that is currently referenced in regulations are from 2014. The consensus meeting was held this month. They've approved it. It'll be released on January 30th and it gets into the nuance of what procedures should be performed in what settings. The last SAC on the FSOF, the allowance of procedures in that setting, I believe that was a great step forward for the community. But this just provides a little extra nuance on what the newest technology is showing and there's been a lot of improvement and research and new technology in interventional cath procedures. So we'd just like the Commission to think about putting the additional charge in there. We also believe, you know, as the open heart volumes, the CABG, those kind of things that have decreased, there is some resistance to programs wanting to give up open heart volumes because of, you know, it's tied to what you can and can't do in your cath lab, and we believe it's important to just look at the latest research on that and the recommendations from the

Society for Cardiovascular and Angiography Interventions to have the experts that are impaneled to review that and make recommendations from there. That's it.

MR. FALAHEE: Okay. Great. Thank you. Questions? Okay. I'll go. You mentioned -- you pronounced it SCAI (pronouncing), is that the --

MR. ERIC BARNABY: Yes.

MR. FALAHEE: Okay. I saw the acronym, but --

MR. ERIC BARNABY: Yeah. It stands for Society of Cardiovascular -- yeah.

MR. FALAHEE: Yeah. So when I was working with the Department last week they were under review, but they hadn't been finalized. But then it sounds like yesterday they came out -- they're not yet final-final yet, but --

MR. ERIC BARNABY: January 30th they'll be out final. And to the Department, yeah, they were not available for the Department as a final document when they were putting together their recommendations.

MR. FALAHEE: Okay. So your -- so your recommendation is to allow the -- if we so choose, the SAC to look at those SCAI standards and to align the Cardiac Cath standards with the SCAI standards to look at?

MR. ERIC BARNABY: At least -- at least review that, yes.

MR. FALAHEE: Okay. All right. That's your first

one. All right. Your second, you talk about hospitals with -- currently with open heart programs and as the number of CABG's goes down, it sounds like maybe those hospitals are thinking of well, can we, should we just stop our open heart program and if we do, what's that mean for our cardiac cath program?

MR. ERIC BARNABY: Yes. That is a conversation that happens when that thought is --

MR. FALAHEE: And your recommendation to the SAC would be what?

MR. ERIC BARNABY: We have reviewed the consensus document from the society and we believe that it's a good step forward. They allow a couple additional procedures in a non-surgical site facility. One of the major ones that's not addressed because it's electrophysiology would be left-side ablation that's not in this document so that probably wouldn't be part of the charge at this point. There's a -- there's a handful of more changes and there's more nuance in site of care that the society puts in the document this time for recommendation.

MR. FALAHEE: And when you say "society" --

MR. ERIC BARNABY: The Society of Cardiovascular Angiography. Sorry.

MR. FALAHEE: All right. No, that's --

MR. ERIC BARNABY: For the record.

MR. FALAHEE: -- I'm just making sure it's there for the record so people know.

MR. ERIC BARNABY: Yes; correct.

MR. FALAHEE: Okay. Thank you. All right. So your recommendation to the SAC then would be what regarding this point?

MR. ERIC BARNABY: At this point would be look at the locations of care and which procedure is recommended by Society for Cardiovascular Angiography, that we would follow that new update if it's reviewed and endorsed by the SAC. But I'd like that newest information to be reviewed and considered for change for those guidelines.

MR. FALAHEE: Okay. All right. To enable the SAC to look at the society's latest recommendations to determine whether to accept, reject, approve some; is that right?

MR. ERIC BARNABY: Right; correct.

MR. FALAHEE: Okay. I'm just -- I'm making sure I understand your request.

MR. ERIC BARNABY: Yes. We want those reviewed and considered for changes to the current.

MR. FALAHEE: Okay. All right.

DR. KONDUR: Chair, Commissioner Kondur. Can I clarify a couple of things there?

MR. FALAHEE: Yes.

DR. KONDUR: So I reviewed the SCAI modalities,

whatever the statement put together. Is it not much different what they're doing right now, just without being a surgery onsite, there's a couple of procedures we cannot do because surgical backup as of today. So because of the technology is advanced and operators are so experienced and they are asking for -- like, if you have a complex lesion, a lot of calcium there, you are allowed to use some equipment without surgical backup. That's what the procedures allow. That way we can help standalone PCI programs because majority of them, standalone PCI program is without onsite surgical backup. They're not even meeting the numbers because they're shipping the pedestrians to these kind of cases. It's like a double edge because this is not meeting volume requirements and you tender the pedestrians to it and they're, like, a lot of plasma issues also happening. And also third is financial burden because you shift from one institution to other institute, so there's a lot of financial burden on the payer as well as the patient as well. So with this allowing this additional procedures to be done on the onsite without surgical backup gives us flexibility to do more procedures and access on the one site. So only, like, now at present you cannot do some procedures, complex lesions we say, B of C lesions, a lot of calcium, a lot of tortuosity. You're not supposed to intervene at present recommendations. If we follow these

guidelines and do the review it at least, so it gives an opportunity to those hospitals to give access to the patients.

MR. FALAHEE: Thank you. Commissioner Guido-Allen?

MS. GUIDO-ALLEN: Just for my own knowledge, SCAI, is it endorsed by or supported by the American College of Cardiology?

MR. ERIC BARNABY: Well, the next step is, yes, and my understanding from the meeting that happened this week is they'll be getting the endorsement from the American College of Cardiology.

MS. GUIDO-ALLEN: They don't have it yet?

MR. ERIC BARNABY: Yeah. They needed to have the meeting this week to be able to formalize.

MR. FALAHEE: Mr. Ferguson?

DR. FERGUSON: So there's been a lot of evolution in care, non-operative care for cardiac disease with a whole array of just an endless -- I mean, it's really rapidly evolving which is exciting and transitions towards safe approaches outside of acute care hospitals with open surgical technique which is great, right, and we're seeing it in all sorts of aspects of medicine, certainly in this arena. There are multiple comments floating through here that intersect between what can be done, where, with what

sort of backup. Right? So there's a recurrent theme in the commentary. And so I think it's reasonable to charge whether it's a SAC or a workgroup or whatever you would advise, to explore that entire continuum. Again, in its relatively broadest form because it ties in -- you know, there's comments about, you know, ablations and pacers, and et cetera, but that whole definition of what can we do where safely and just put it into one big grab bag, let them explore it, come up with a set of recommendations, align it if appropriate with SCAI. If not appropriate with SCAI, I want it with whatever. But defer to the experts on it. I think there's a great opportunity here and -- frankly, to get some of the work out, outside of the open heart centers and serve our communities better.

MR. FALAHEE: Thank you. Other -- don't leave yet. I don't know --

MR. ERIC BARNABY: Yeah.

MR. FALAHEE: -- any other questions? Okay. Thank you very much. Appreciate it.

MR. ERIC BARNABY: Thank you very much.

MR. WIRTH: Next I have Dave Walker, Corewell.

DAVE WALKER

MR. DAVE WALKER: Good morning, Chairperson Falahee, Vice Chair McKenzie, and members of the CON Commission. My name is Dave Walker and I am here on behalf

of Corewell Health. Thank you very much for the opportunity to talk today about the Cardiac Cath standards.

During the last review of the standards, significant changes were made to allow cardiac catheterization labs in freestanding surgical outpatient facilities. This change was made to align with CMS policies, but more importantly, to create additional access to these critical services at a lower cost. As is often the case after a significant policy change, small issues emerged that need to be cleaned up. One specific example of this is in the definition of diagnostic cardiac catheterization. The current definition ends with a statement that pacemaker and ICD implants can be performed in operating rooms rather than cath labs if the OR is located in a hospital service -- or, excuse me -- hospital that also has cardiac cath services. We do not believe that the last SAC intended to restrict the ability of an FSOF approved to perform cardiac cath and CIED procedures to be able to also perform pacemaker and ICD implants in the OR. We think simply the last SAC just missed this minor update.

To that end and since the Department is already recommending a SAC be formed, we respectfully request the Commission adopt the Department's recommendation, but add the following charges: Modify the definition of diagnostic cardiac catheterization service to allow permanent

pacemakers and ICD implant procedures to be performed in an operating room located in FSOF approved to operate a CIED service and review the cardiac cath definitions to ensure that they align with what CMS has approved for the SA setting. By allowing a SAC to look at these issues, we will be able to determine if these changes would improve on the positive policy changes from the last SAC and continue to ensure that the patients of Michigan to have access to affordable, high quality, cardiac catheterization procedures. Thank you again for your time this morning. I'd be happy to answer any questions Commissioners may have.

MR. FALAHEE: Kenny?

MR. WIRTH: Thank you.

MR. DAVE WALKER: Or the Department?

MR. WIRTH: Not a question, but I would agree with what Mr. Walker just put forward about that being a drafting error after the conclusion of the last SAC. We went through and reviewed the presentations of the Commission, the transcripts for that Commission meeting and the SACs and it was part of the recommendation of the Commission, it just wasn't -- for whatever reason got missed when the definition was updated at that point so we're open to adding this to the charge.

MR. FALAHEE: So this is Falahee. Before -- don't leave yet, Mr. Walker.

MR. DAVE WALKER: I love being up here, so I'm happy to stay.

MR. FALAHEE: Mr. Walker suggested a added charge to the SAC, but, Kenny, you're saying, oops, the Department knows that was a mistake so the Department can fix that on its own without a charge being added?

MR. WIRTH: Well, I think we'd like to work with the SAC to make sure that the language is good.

MR. FALAHEE: Okay. So keep the -- okay. Got it. All right. Okay. I'm just making sure.

MR. WIRTH: It was just -- yeah, it wasn't included as a recommendation that we were recommending for a SAC but we're revising that here to --

MR. FALAHEE: So for purposes of potential charges to a SAC, keep the -- if the Commission so chooses, keep that one on there even though we know it's a technical fix?

MR. WIRTH: Yeah.

MR. FALAHEE: Okay. Got it. All right. Thank you. All right. Sorry. Questions from the commissioners?

DR. KONDUR: Commissioner Kondur. I think Tulika and to the Department, I think we approved in the previous SAC pacemaker implants, ICD, and gen change accepted by the ACD left side. And is any error language? It was approved as of two years ago, year back.

MR. WIRTH: Yeah, I think Dave mentioned that in

his comment that the language that was approved ended up limiting where those could take place -- inadvertently limiting where those could take place; that the intent when it was passed was to allow those procedures in ASCs, but the language -- and I believe what you stated, Dave, was that it limits it to only in the freestandings; right, is within your comment?

MR. DAVE WALKER: Yeah. Limits only to the hospitals.

MR. WIRTH: Correct. Sorry.

DR. KONDUR: I think we need to review the language. It was approved in the freestanding outpatient facility as long as your OR. It was approved. It was six months ago. If you look at the language, it is approved. We don't need to add additional charge. It was already approved and based on that language I think the Department is reviewing the ASCs and reviewing the applications. They are approved in a couple of centers.

MS. NAGEL: Yeah, we do want it on the charge just to make sure the language gets right this time.

DR. KONDUR: Corrected? Okay.

MR. FALAHEE: Right. That's -- yeah.

MR. WIRTH: Yeah, we don't want to accidentally miss it again this time and then end up back here asking to kind of review that language in --

MR. FALAHEE: Yeah. I think the Department and Commissioner Kondur are both saying the same thing coming at it from a different direction. We want to make sure the language is right and I think that that's the ultimate goal of everybody. Okay. Questions for Mr. Walker? Okay.

MR. DAVE WALKER: Thank you very much for your time.

MR. WIRTH: Next I have Tracey Dietz, Henry Ford.

TRACEY DIETZ

MS. TRACEY DIETZ: Good morning, CON Commission. My name is Tracey Dietz. I am the director of strategic planning with Henry Ford Health System. Thank you for the opportunity to make comments on behalf of Henry Ford.

We appreciate the Department's recommendations that they made in regards to initiating a SAC to focus on rural access as well as to add the definition of STEMI to the standards. We feel these recommendations are appropriate to ensure access is key while still balancing cost and quality.

The concern that I did want to raise is that we're not comfortable with the interest of adding a 30-day notice to the Department for discontinuing a service. While we agree it's really important to work with the Department whenever possible and to reach out and talk through potential upcoming changes, reductions, closures of

services, the concern that we have is sometimes those aren't necessarily known and emergency situations do come up with lack of knowledge. And so for access specific with cath lab, if something technical fails and we do have to close down an OR and then make a decision not to replace, to reopen that cath lab -- I think I said OR, that cath lab -- that doesn't always allow us then to give that 30-day time frame notice to the Department and we don't want that to become a situation where we're out of compliance. Best, you know, good faith effort, pre-thought through, you know, ideas about closing something down or reducing services? Absolutely. We totally agree it's important to include the Department in those kinds of discussions. We're just concerned that by adding this type of language to the standard, it causes a facility to potentially be out of compliance when that was not at all the intent, the purpose, and it was kind of an uncontrollable situation that they're facing. Thank you for allowing me to offer comment. Happy to answer any questions you may have.

MS. GUIDO-ALLEN: Commissioner Guido-Allen. The way I read the recommendation, it's planned decrease or discontinuation. So if indeed you have an emergent situation where you have to close a cath lab and then take the time to -- that wouldn't necessarily require a notification. But then as you work through the process to

determine whether or not you're going to spend the money to replace the equipment or whatever, would that allow you then the time to notify the Department?

MS. TRACEY DIETZ: If we're -- if -- I think it's -- it's -- it's in the language and if we're careful on how we draft that language, then I think that would be appropriate. Absolutely.

MR. FALAHEE: Commissioner Ferguson?

DR. FERGUSON: This may be a question for the Department. Do we have notice periods for other services? So is -- are there parallels or is this a unique one off?

MR. WIRTH: Tulika?

MS. BHATTACHARYA: So we are proposing to add this language to all of the standards that are up for review this year due in part -- and I don't know if it is an effect of COVID, but we are observing more and more facilities are not just decreasing the level of service, they are completely closing down services in their communities which the Department is not aware of. We are only finding out through compliance review. So a lack of access to care is being created without any notification to the Department and we thought there is enough language in the statute and rules to make that happen, that notification, make it official, but that's not happening so we wanted to put language in the standards to make it clear what the expectation is. And to

answer Commission Guido-Allen's explanation, if you are going through a temporary phase and you are deciding whether we are going to discontinue or not, that is not the final discontinuation or closure of the service. But on the date you have gone through your deliberation, your research and analysis and you are making a conscious decision to shut down a service or close down a facility, we are just requesting that you notify the Department so we can keep track of the service levels in the community.

DR. FERGUSON: So a follow-up question on that. If this is primarily about Department awareness that service is no longer being offered which is different than saying Department's going to somehow acutely manage in that 30 days to find creative solution, why wouldn't we just say that in the event that services are permanently shut down or are shut down, anticipated for more than X number of days, notice is required within X period of that shutdown? You know, notice is required at time of the shutdown or within two weeks of the shutdown? I don't know, but just pivoting --

MR. FALAHEE: I appreciate the comments. I'm sure the Department does. I think we can -- they hear where we're coming from and your comments. I think when the word "planned" is in there, what you were talking about isn't planned. That's urgent, it's emergent, machine shuts down,

whatever.

MS. TRACEY DIETZ: Absolutely.

MR. FALAHEE: And that's what Commissioner Guido-Allen was talking about. I think we can come up -- I think the Department can come up with language that addresses what we've heard today both from you at Henry Ford and the comments around the Commission table as well. And then you'll have to bring that back to us anyway for approval or friendly edits. So I think -- I think that'll work. All right? All right. Any other questions? Thank you very much.

MS. TRACEY DIETZ: Thank you.

MR. WIRTH: Next I have Dr. Shrin Hebsur of Trinity.

MR. FALAHEE: I'll just add I appreciate everyone's patience around the Commission table and in the audience as we work through these issues because it's important that we understand and we do our best to get it right. So thank you.

SHRIN HEBSUR, M.D.

DR. SHRIN HEBSUR: Thanks for having me. I'm one of the electrophysiologists and head of EP at one of the Trinity Hospitals called St. Mary Mercy Hospital. As an aside, I was on the subcommittee looking at charges for devices such as pacemakers and ICDs in the ambulatory

surgical center.

And, you know, kind of my comments, piggyback on the first two comments. The first is, is that I think as cardiology advances, the different disparate fields within cardiology, whether it's interventional cardiology and electrophysiology, they're actually not converging. They're actually diverging and the expertise and comfort field between one field and another is getting further and further apart. And I was actually asked to comment on the cath CON, you know, which comprised entirely of interventional cardiologists with regard to several different charges, including performing left-sided ablations and doing devices in AFCs and, therefore, you know, some other public comments were made and we made a subcommittee just to discuss devices in ASCs.

And now, you know, as we are reviewing these charges for upcoming cycles, my ask is that we revisit the left-sided ablation charge and actually involve this in a subcommittee of electrophysiologists. Therefore, we may be able to, you know, actually look at the different actual need of this and also the nuances of the field and look at the data on the safety of left-sided ablation. Left-sided ablation is now becoming the kind of number one thing that electrophysiologists are doing far more than just pacemakers and ICDs. And a lot of, you know, therapies that we offer

for our patients is, you know, dependent on left-sided ablations whether it's in a suburban hospital that doesn't have CT surgery backup and, as the prior commenter alluded to, the -- you know, the number of CT surgery sites may be diminishing. I think this is very, very important because in my honest opinion the safety of this procedure is incredible at this point and we have a lot of data that has not been, you know, necessarily updated with Heart Rhythm Society guidelines, but there is now new verbiage within the HRS allowing this. I think it would be a good idea to have it revisited within a panel of electrophysiologists just as we did with ASCs because that was -- the interventional cardiologists took the -- you know, the subcommittee's guidelines or recommendations. And so I think we should do this for the next one.

DR. KONDUR: Can you be more specific regarding a location of the left-side ablations? You're saying that it should be performed without surgical backup and as well as ASC or what is the proposal?

DR. SHRIN HEBSUR: Well, my proposal -- again, my proposal is to perform this in hospitals that don't have CT surgery backup. Certainly there are states that are doing this widely in ASCs that could be -- it might be kind of a big quantum leap for a state where we're not doing that and we're only performing them in sites with CT surgery backup,

but I think, you know, my recommendation would be to at least have this formally looked at in a subcommittee in hospitals that don't have CT surgery backup.

MR. FALAHEE: Other questions? Thank you for summarizing. Thank you for your testimony. Appreciate it.

DR. SHRIN HEBSUR: Thanks.

MR. WIRTH: That was all for public comments. I will add that this was another one that Chip and I discussed last week and this is something that in the previous chair's report after reviewing that, there was a request to have more electrophysiology experts on a future SAC to look into this. So this is another one where I think we're okay exploring this in a SAC just to see kind of what the conversation is with those additional experts at the table.

MR. FALAHEE: And just for the Commission's benefit, then we'll get to Dr. Ferguson. There's always a pre-call the week before with the Department or maybe a couple weeks before the CON Commission meetings with the chair and the vice chair to talk about issues and to review what's coming up on the agenda. And when we had the call last week or the week before, I asked Kenny, I said, "Didn't this come up before? Can you look? Can you figure out where we're at and other suggestions as well?" So that's very common for that pre-call to have a good discussion back and forth between chair and vice chair and the Department to

give us a heads up and the Department a heads up or at least an acknowledgment, okay, where are the chair and vice chair coming on these issues? So a good interactive process just so you know that. So with no more witnesses on this issue, open it up for Commission discussion. Any discussion items? What I've heard so far then -- oh, go ahead, Commissioner Ferguson.

DR. FERGUSON: It's fine. Go ahead.

MR. FALAHEE: Okay. What I've heard so far from the witnesses, if you look at -- it's in our packet somewhere, but -- oh, yeah, here we go. I don't have a page number. Sorry. But what I'm hearing is -- from the witnesses -- to add -- if we decide to appoint a SAC, to add to the charges that Kenny already summarized, to add to it align the standards with the SCAI recommendations, assuming they're finalized and approved by the American College of Cardiology. That's number one. Number two is talk about hospitals with mature programs be allowed to -- with cardiac programs be allowed to maintain their programs in a non-open heart hospital. That's number two. Number three -- and, Kenny, I'm going to ask you to correct me if I get this wrong as well. So I'm looking for the Commissioners as well -- to review the definition -- and this came from Mr. Walker, the two from his -- review the definition of diagnostic cardiac services to allow pacemaker and ICD

implementation procedures, number two, to review all the definitions to ensure alignment with the CMF's definitions. I think as part of that is that technical correction we already talked about. And the last thing we heard was to consider allowing elective PCI hospitals to perform left-sided cardiac ablations. So those are the five potential added charges to the SAC as I understand it right now. Commissioner Ferguson?

DR. FERGUSON: I guess what I would ask and, you know, there's a lot of detail in there and it's important detail and there's profound differences between all of those five charges. But I think what I'm hearing is they all line up around a notion of a safety focused approach. What can be safely done, where, with what backup? And so I would consider either labeling the whole charge under that and these are sub-bullets or adding a final line item that gives the workgroup latitude to explore the general concept of safety driven, decision making around this of what can be done safely where. Not around -- you know, I'm not saying expand it out to access and numbers and this or that, but simply this notion because I suspect there's other corners of that same notion. And what I don't want to do is be back here because we said, "Oh, you can do it with this catheter, but we didn't say you could do it with this catheter" or whatever, you know, some minor technical detail. So I

would -- I would give the SAC a little wiggle room.

MR. FALAHEE: Okay. Other comments about that?

DR. MCKENZIE: Yeah. My comment back on that -- this is Commissioner McKenzie. And I may misunderstand this. I may ask Commissioner Kondur to weigh in on this. But my understanding is that there are large bodies that are looking at what can be safely done. Right? And I think what I'm hearing is let's align our standards with those bodies that are already looking at this. So I worry a little bit about expanding it too broad and then having decision making happen within our own kind of Michigan CON.

DR. FERGUSON: No. I'm not -- I'm not saying invent our own. I absolutely think we should look at whatever the bodies are out there. SCAI is one. I'm going to guess that there may be others. I don't -- I don't know enough to say that they're the end all, be all. What I don't want to do, again, is have -- be back here because we give approval on one type of, you know, implanted cardiac device but forget to comment on the next implanted cardiac device. And I can't rattle off the laundry list of names, so I can't devise the charge.

DR. KONDUR: Commissioner Kondur. Back to Commissioner McKenzie's point. I think we don't need five charges. First three is one, actually. Look for the facilities that can safely perform the procedures under

societal recommendations put together and it will expand not more than two, three procedures what we are doing right now. So just put charge one as what can safely perform without onsite surgical backup and under societal guidance. And two, I would add a charge, ask chairman is there any way we can align the payer? CMS is expanding every year adding some codes to be performed in the either standalone PCI without surgical backup or to the ASC. Their momentum is, like, going -- like every year they're changing. Is there any way we can add a charge instead of coming back every year, every other year from the hospital, from the other lobbies, here, can we add this service line to form a SAC? Is there any way we can come to language say that we'll follow the CMS payer, whatever is allowed in the facilities we follow through?

DR. MCKENZIE: Commissioner McKenzie again. Maybe I have missed, again -- you know, and I will be fine with kind of bucketing this under one. Commissioner Ferguson, that may have been what you were suggesting was, like, just open it up and tie it to the -- you know, to the guidelines and I'd be fine. I see both SCAI and CMS cited and I think my interpretation was that is exactly what the recommendation was from the entities.

DR. KONDUR: And this is -- was asking some specific, not like a payer allowed codes because they're

asking some specific. Last year they allowed left -- right-side ablation. This year may allow left-side ablations and following year they may add some more codes to be performed. So instead of revisiting every three years, why don't we form a single payer whatever they are allowed, add language to it so it can be performed?

MR. FALAHEE: Yeah, I get that because it's similar to surgical procedures. Every year CMS says these procedures can be performed in an outpatient facility.

DR. KONDUR: Outpatient or standalone, whatever.

MR. FALAHEE: Yeah; right. And I think that -- I know the Department always likes to be precise, but I think it makes sense as we're seeing more and more that's going outside of an acute care hospital to the extent that, let's say, CMS comes up with a formal "these procedures and this procedure code can now be performed in an outpatient facility," I think it makes sense. We can have a living document that we don't have to update it every three years. I think that makes sense. In terms of one charge versus four or five? I don't think it matters. I think that I would be hesitant to say to the SAC whatever is approved by a society go forth because there could be societies out there that are not just -- not the bottom five. Let's put it that way. So I think that's why I was going to specify, you know, SCAI and American College of Cardiology and all

that. That's why I was piecing it together. I think some of these don't fit neatly into one specific charge. That's just my thought. Welcome other comments.

DR. MCKENZIE: This is Commissioner McKenzie again. I think if we can craft the charges to give the latitude to -- again, to the experts within the SAC to look at this? I agree with the payer piece. Again, you know, the kind of caveat that I'll put around that is I think CMS put in a whole bunch of things and then pulled back on them, too. So there is kind of benefits and risks to tying through to payer guidelines as well, but I think that can all be explored and discussed with the SAC on what the best approach is.

DR. KONDUR: I agree with Commissioner McKenzie. It's better to put together language, give it to the experts, let them come together. And also second point is back to the electrophysiologist. When we form a SAC, make sure it bands both the EP, electrophysiologists, and also interventionalists to equal so that they can come up with the conclusion in that -- both segments.

MR. FALAHEE: Yeah, that addresses the future. I will say it now -- I was going to say it later. Any time we form a SAC, I always -- as chair I always say, "Please, if you're interested in being on the SAC when the notice comes out, nominate yourself" because what the chair and vice

chair do is we work with the Department to make sure that we have a balance so it's not all skewed one way or the other, and the more people that nominate themselves, that's good to have a long list to review and then the chair and the vice chair have the pleasure of appointing a chair and a vice chair. And in the past when I know there are two sides on an issue, the chair and the vice chair will be from separate sides. And I'll say to them, "You work it out and come back to the Commission." So, please, for those in the room when the list -- when the nominee process begins, please submit your names so we have a balance on there. Any other discussion?

DR. MACALLISTER: Chairperson, I'm wondering about LARA requirements as well on this, if there is any, with changing or shifting any of the components now?

MR. FALAHEE: I don't think LARA -- I don't think there are any issues that I know of with LARA on this one. I turn to my friends on the other side of the table.

MR. WIRTH: I'm not aware of any at the moment.

DR. MACALLISTER: I just know that with some of the requirements of ambulatory surgery and what would be needed in the facility, but if you think it's addressed, that's great. Okay. Thank you.

MR. FALAHEE: All right. Kenny, anything else to add before we proceed with a motion?

MR. WIRTH: I don't think so.

MR. FALAHEE: Okay.

DR. KONDUR: I have one question for the Department. So as a standalone PCI hospital are -- like a surgery center, when you are affiliated with a practice and prefer the transfers and review process, what is the basic requirement? They interview all the cases from the -- where have a transfer agreement or only 25 percent or 20 percent or random? What is the process in place? Tulika can answer.

MS. BHATTACHARYA: Yeah. So we do have, like, a provision in the standard and I think there are, like, 10 to 12 items that should be part of your consulting agreement with the open heart surgery hospital. So if and when we evaluate performance of an FSOF, ASC, or a standalone PCI hospital, we will be reviewing if you are maintaining those items as part of your consulting agreement.

DR. KONDUR: Well, now the statement was not clear. The (inaudible) to things they do in all the case for the standalone PCI program what are performed, even though we have a two accreditation board. There's Corizon and also the ancillary report. You guys review 25 percent of the cases submitted by Corizon, whatever that accreditation body. And the (inaudible) is under the impression that they need to review all the cases that was

performed in the standalone PCI. The language was not clear. Can you look into it, please?

MS. BHATTACHARYA: Yeah, I can -- I would not want to make a comment without reviewing. Because if -- for example, if the standards say each case needs to be evaluated, that is very clear. But if the standard do not say that specifically, then it doesn't have to be 100 percent of the case. So I want to read the language in the standard and I can get back with you.

MR. FALAHEE: Great. Thank you. Yeah, that will be outside of this -- this SAC.

MS. BRADSHAW: Yeah.

MR. FALAHEE: So I'll open it up for a motion.

DR. MCKENZIE: This is Commissioner McKenzie. Let's see how good I can do with this. I'm going to move that the Commission form a SAC or the Department help to form a SAC with the charges that the Department recommended within our packet -- I'm not going to walk through each of the charges. They're listed there -- with the addition of the five additional charges that Commissioner Falahee walked through, and that the language around those charges be delegate -- be worked through between the Department as well as the chair and the vice chair, and that the chair and the vice chair assign the chair and the vice chair of the SAC as well.

MR. FALAHEE: Is there support for that motion?

DR. KONDUR: Commissioner Kondur in support.

MR. FALAHEE: Discussion? All right. Motion on the floor. All in favor please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Anyone opposed raise your hand. That motion carries. Thank you for a very good discussion.

(Whereupon motion passed at 11:36 a.m.)

MR. FALAHEE: We will now take a break. And it's 11:36. Let's take a 10-minute break and then come back. Thank you. We'll pick up with Hospital Beds.

(Off the record)

MR. FALAHEE: Okay. Let's everybody come back together. And just as a note for everybody when you're speaking, if you could speak with the microphone in front of you so everybody can hear, not just around the table, but in the room as well. So thank you very much. And Kenny has the mute button for all of us so if he doesn't like what we're saying, he just turns us all off.

So let's move to our next topic which is Hospital Beds. And, Kenny, I'll turn to you as usual to summarize where we are and how we got where we're at right now.

MR. WIRTH: Thank you. And I'll add the mute button is a couple steps away from me, so I won't be that quick with it, but I'll do my best to scurry over if need

to.

So public comment period was held from October 7th through October 21st of 2022. We received comments from 11 organizations and 18 individuals not representing an organization. A summary of these as well as the comment letters are included in the electronic binder. All comments received are in support of continued regulation of Hospital Beds. The Department supports continued regulation and recommends that an informal workgroup be formed to look at some of the items brought forward. These include reviewing the Hospital Beds methodology in limited access areas criteria, reviewing the addition of language to address what should happen to a long-term care -- or, sorry -- a long-term acute care hospital or LTAC when the host hospital closes, reviewing the addition of a market survey requirement if a plan to relocate or replace a hospital, reviewing the addition of language pertaining to a rural emergency hospital or REH. And I'll just add that "REH" is a new CMS designation for what is essentially a hospital without inpatient beds. Senate Bill 183 became effective December 22nd, 2022, and has some requirements for how CON needs to monitor temporarily de-licensed beds so that's why we're asking for a workgroup to review that. And then other technical edits by the Department if needed.

So if a workgroup is to be seated, then a written

charge will need to be drafted and voted on by the Commission or the Commission may instruct the chair to write the charge consistent with the language presented at today's meeting. The chairperson would also appoint a chairperson and vice chairperson for the workgroup. After the workgroup completes its work, it would then bring its recommendations to the Commission at a future meeting.

MR. FALAHEE: This is Falahee. Thanks, Kenny. I have one question. When you talk about a market survey, help me understand what that is. I know it was -- it was removed in 2012, but remind me what that market survey would require if you know.

MR. WIRTH: I don't know off the top of my head the exact requirements. That was part of the original hospital group's methodology which was replaced by the newer update. So -- sorry. So that market survey was omitted when the newer language came forward and we'd just like to see if that's something that --

MR. FALAHEE: Okay. Part of the workgroup?

MR. WIRTH: Exactly.

MR. FALAHEE: Okay. Thank you. All right. Any questions from Kenny at this point before we open it up for public comment? All right. Thank you. Kenny?

MR. WIRTH: All right. First up I have Jack Curtis of Charter Township of Oxford.

MR. FALAHEE: Mr. Curtis is -- yeah, Mr. Curtis is also a regular at the Commission, so --

JACK CURTIS

MR. JACK CURTIS: I am a regular. I guess I want to apologize. I am the one that put 80 pages in your 244 page document.

MR. FALAHEE: No, it was 94 pages.

MR. JACK CURTIS: It was 94. Thank you, James. Because I am here to sell something and I'm here to support the initiative and your identified issues of reviewing Hospital Beds methodology to determine the need in limited access areas, especially Oxford.

We have an anomaly. In your packets you saw I included SEMCOG data, the 2020 census data, hospital distances from Oxford, community support from around the area -- Brandon, Addison, Orion, independents. Even though they have hospitals closer, we are still interacting with them and the people in their communities live and their families live in our community. I want you to take into consideration the infrastructure we had implemented into our community based on -- and I'll reiterate the numbers. We have a limited access area need in 2018 of 117 beds for an acute care facility. In 2019 it went to 121. And all of a sudden in 2020 it went to zero. Zero. But yet we still have four major hospital groups that saw these local area

access needs come out and show that we have a need for this amount. Four major hospital groups have bought up 100 plus acres of prime commercial property in our community waiting for a CON need to come back out. The 2020 really kind of wreaked havoc in the entire community.

I give you that packet, looking at it as such, the data, you don't really need to spend any money with Paul Delamater again to do a survey of methodology for the Oxford area. It's an anomaly. We have the Buick -- or we have the GM plant in Orion, $4 billion investment and that's 17 miles to the nearest hospital from Oxford. And within ten miles there's 200,000 people that live there. To the north in Lapeer, McLaren, that's the next closest hospital, is 17 miles. Lapeer will be making a huge announcement this week where they're going to have investments of billions of dollars. Again, being on the 69 corridor between Flint and Canada and all through Chicago.

I just reiterate again we are growing. Urban sprawl is coming our way. I was talking to Vice Chair McKenzie earlier. Last year we issued 1,766 building permits in Oxford, a community of 20,000. Since 2010 census it's doubled. Our communities are growing. And these aren't businesses, these are people living there. So with that, I'll take one second. I know I pulled two people off your agenda and I just want to read something if I can?

MR. WIRTH: Chip, that's --

MR. FALAHEE: Quickly, please.

MR. JACK CURTIS: Okay. I'll read it quickly. This is from our State Representative Schreiber who was here, Josh Schreiber. And he was very sad. He had to leave to another meeting. But he fully supports our activity in getting the CON to revisit the Oxford area for a local area access of need.

MR. FALAHEE: Great. Thank you very much, Mr. --

MR. JACK CURTIS: Thank you. Any questions?

MR. FALAHEE: -- any questions of Mr. Curtis? Thank you very much for being here again.

MR. JACK CURTIS: Thank you.

MR. WIRTH: Next I have Matthew Majestic of the Oxford Fire Department.

MATTHEW MAJESTIC

MR. MATTHEW MAJESTIC: Thank you, to the Chair and the Commission for giving me a few minutes of your time. I'm the -- my name is Matt Majestic. I'm the fire chief in Oxford, 36-plus years in emergency medical services. I started out with Warren, Sterling Heights, West Hamtramck, West Bloomfield. Right? We couldn't go anywhere you couldn't swing a you-know-what without hitting a hospital. I've moved out to Oxford now to take over as the fire chief there and it's a whole different story. When I was in

Macomb County, Oakland County, Wayne County we had time of call to transport to clear in-service times of 30 to 40 minutes. Oxford, two hours to two and a half hours on average from time of call 'til we're back in service. We have seen our call volumes go through the roof. Right? I have seen our hospitals go, right, from being a few miles away to having to deal with 16 to 23, 25 miles away. It's just ridiculous. And now we're at a point where once we get to a hospital, we're waiting in the ERs half hour, 40 minutes, 45 minutes, up to an hour is not an anomaly. It's a regular thing now because they're full.

I just -- I struggle with trying to -- you know, I wanted to give you some stuff. I was going to say oh, I'll check the numbers from last night but I can't use last night's because of the stupid storm. Right? That would truly skew our numbers. But just going the day before, two hours, two and a quarter hours, two and a half hours, two and a half hours, two and a quarter of hours from time of call to back into the community. We only have two stations running ambulances. We're constantly relying on our neighbors. We have to then -- you know, they rely on us, we rely on them.

Mr. Deighton spoke about a 9-year-old girl. That was our patient. On that patient alone, almost two and a half hours; 45 minutes of that was sitting in the ER with a

9-year-old, strapped, tied down to stretcher waiting for a bed. It's unacceptable. It's absolutely unacceptable.

And lastly, the day of the shooting, we transported patients 16 miles away, 17 miles away, 17 miles away, and 37 miles away to McLaren Flint. What do you think that does to the golden hour of trauma? It's brutal. We need to do something about this. I really -- I beg you to reevaluate and come up with a change to the methodology for calculating a need because we have a documented, identified need for a change in this process. Thank you.

MR. FALAHEE: Thank you very much for being here. Thank you for your comments. Questions? Thank you for the time.

MR. MATTHEW MAJESTIC: Thank you.

MR. FALAHEE: Appreciate it.

MR. WIRTH: Next I have Joseph Madore from Village of Oxford.

JOSEPH MADORE

MR. JOSEPH MADORE: Good morning, Commissioners, members of the Commission. Thanks for allowing us to have our say here. And Chief Majestic's a hard act to follow. He's been there, done that as they say. But I want to mention a couple other aspects maybe that sometimes aren't heard or taken into account.

When our officers have to take somebody, an unruly

person on the side of the road to a hospital for a blood draw, whether it's DUI or OWI, it's those miles, 15, 20 miles away, the officers are there, they get their blood drawn and done at the warrants and all that stuff, they're out of our area for a couple hours. Our community sometimes only has one officer on and so our community then is without that officer because of the distance the officers have to take these persons to get the work done. It's just too long. One other aspect the problem that far away is we do have top notch ALS, BLS, ambulance service. Oxford Fire provides that service and they are top notch, but they still cannot provide the level of care that an emergency room at a hospital can as good as they are.

We've probably all heard of the term "food desert," "grocery desert," right in urban communities where they don't have food and the long-term negative effects that can have on people's lives. Our community is suffering from a hospital bed desert. We have this problem and we aren't talking about some northern Michigan community that we visit on the weekends. People expect that up there. We're talking in Oakland County, one of the biggest, vibrant growing counties in our state and yet here we are. We might as well be on Mars in some senses.

So I'd ask you to reconsider the Certificate of Need process and those data points that you use. The

hospital providers are willing to fill this serious need and our residents' lives and our first responders' lives, they deserve to be part of that consideration. Now, some of the information I give you is kind of anecdotal, but I always live by an old term I heard years ago. It says not everything that could be counted counts and not everything that counts can be counted. Sometimes it doesn't show up in a spreadsheet, but the need is still there. So thanks.

MR. FALAHEE: Thank you. Any questions? Okay. Thank you for your time.

MR. WIRTH: Next I have Sean Gehle, Trinity.

SEAN GEHLE

MR. SEAN GEHLE: Good morning, again. I'm Sean Gehle with Trinity Health Michigan. Just wanted to indicate our support for the formation of a Hospital Bed SAC as distinct from a workgroup to potentially look at these issues. Given the magnitude of some of the issues that have been brought forward, it seems like a SAC would be a more appropriate body to debate and discuss some of these issues. I don't remember a scenario where we've had a Hospital Bed workgroup versus a SAC at least in recent memory. I could be wrong about that. But given the issues and the magnitude of the issues, we'd just urge support of the formation of a SAC. Thank you.

MR. FALAHEE: Any questions? Okay. Thank you.

MR. WIRTH: That's all the public comment that I have.

MR. FALAHEE: Okay. Great. Commission discussion? Let me ask a question of the Department. So Mr. Gehle suggested forming a SAC versus a workgroup. Department response?

MR. WIRTH: We have a very in-depth charge for Cardiac Cath. We're anticipating a very in-depth charge for Surgical Services as well. So our recommendation is to form SACs around Cardiac Cath and Surgical Services. And due to our ability to manage all of these meetings, we're somewhat limited to two SACs in an annual period. Three would be very difficult, I think, from a Department standpoint to staff all of those, have them line up on Thursdays and still perform other duties as well. So that's why we recommended a workgroup on this one is to manage the workload that we're going to be looking at from this Commission and outside of the review of the methodology charge, the other ones are somewhat --

MR. FALAHEE: So let me ask a hypothetical which is hard to imagine. But if the Hospital Beds issue was all by itself, would you recommend a SAC for that or a workgroup? If there was nothing else on the agenda, if you will, other SACs or other workgroups. I don't know the answer. I'd welcome what you all think.

MR. WIRTH: I mean, I don't know how I feel speaking on behalf of the Department. I'd still think I would look at a workgroup for this one just because there's not a ton on the agenda for this group and we'd be able to start sooner than a SAC. We'd have about a three to four month lead up to a SAC when we're trying to receive nominations.

MS. GUIDO-ALLEN: Kenny, can I ask a question?

MR. WIRTH: Yup.

MS. GUIDO-ALLEN: What -- and I guess I should know this. What outputs are different between a SAC and a workgroup?

MR. WIRTH: In terms of what they deliver to the Commission?

MS. GUIDO-ALLEN: Uh-huh (affirmative).

MR. WIRTH: It would be same recommendation coming out of a SAC or a workgroup, it would just be the structure of the body itself.

MR. FALAHEE: And I ask because Kenny's right. As we all know and many in the room know, when we form a SAC, they don't get formed quickly. And sometimes we've had to go back, I think the record is four times to ask for nominations to a SAC and it can take up to a year to form the SAC. And Mr. Curtis and friends have been here multiple times and I think to me expediency is the goal here. And

given what else is on the agenda and in front of the Department, I think a workgroup makes sense to me because as Commissioner Guido-Allen talked about, the result is the same when it comes back to the Commission. The work can be in-depth. I mean, face it, the Psych, we just talked about? That's a workgroup, folks. So I don't have any issue at all with making this a workgroup and making sure that good work comes out of it. Beth?

MS. NAGEL: I just wanted to add to, you know, maybe you could hear it in Kenny's voice, but it's something we struggled with quite honestly deciding between the two. And the other issue that hasn't come up, the difference between a SAC and a workgroup, right now we can hold workgroups virtually. And given that this is an issue of a -- you know, a community and community need, we didn't think it necessarily made sense to bring everybody to Lansing to have an issue, to discuss this issue when it could be done virtually. There are pluses and minuses honestly to both approaches and we just tried to pick the one that could meet more of our needs quicker.

DR. FERGUSON: So you'll have to guide me if this is a violation of form. But given this discussion, I wouldn't mind posing a question back to Sean if that's okay?

MR. FALAHEE: Sure. If it's okay with Sean?

DR. FERGUSON: What -- so you're asking for a SAC

versus a workgroup based on this conversation why?

MR. FALAHEE: Sean, if you're going to make comments, for Marcy's benefit and the record, please come up to the podium.

DR. FERGUSON: I'm just trying to understand --

MR. FALAHEE: No, I --

DR. FERGUSON: -- I'm still struggling to understand when we use which one and I'm guessing that there must be an opinion. I mean, I don't know if it's valid or not, but --

MR. FALAHEE: No; no. That's fine.

SEAN GEHLE

MR. SEAN GEHLE: So having participated in workgroups versus SACs, workgroups, as you all know, anybody can come. You could have different folks one workgroup to the next workgroup. SACs you have designated individuals that are nominated. No disagreement that it's been difficult in the past to seat SACs. I'm not sure that it's been difficult to seat Hospital Bed SACs versus other kinds of SACs. But regardless, understand it's just that if you want the continuity and you want the more formal recommendation and you don't know the composition of each workgroup, that continuity and that decision making is, I guess in our opinion, not as formal and not as consistent going forward in a workgroup environment. It's more ad hoc

and it just doesn't seem to have the same process benefits of having a SAC and seating the same people and assuring the composition is balanced. Because in the workgroup you can have folks -- you can have whoever brings the most people to a workgroup or what you get. And so if you get votes -- we've had conversations or we've had votes in the past where there has been -- that issue's been raised about, you know, individuals versus entities that are represented. That's all.

DR. FERGUSON: So my question to the Department or, Chip, to you is, is there any way without going all the way to the formality of a SAC to create slightly more explicit guidelines around a workgroup in general? Because it sounds like it's a little bit of a free-for-all. You know, should there be some guiding principles or more explicit guiding principles around how workgroups operate?

MR. FALAHEE: Yeah, this is Falahee. It can be a free for all as Mr. Gehle pointed out, especially with Zoom. And if you're -- if you're saying, okay, we're going to have a vote on January 26th on these issues, you could have people clicking into Zoom that have never been at the workgroup before and voting yea or nay and then potentially stacking the deck yea or nay. So I think that's something we have to be aware of and cognizant of because we don't want that happening on any workgroup.

DR. FERGUSON: Right. Yeah. No, I'm talking in general. I'm really talking about general guidelines around the workgroup.

MR. FALAHEE: I'm not sure of what -- Sean, I think we're set. I think -- yeah. We know where you are if we need to call you back.

MR. SEAN GEHLE: Thank you.

MR. FALAHEE: I'm not sure what the Department can do under its current standards, vis-a-vis workgroup restrictions or rules to go by.

MS. NAGEL: I would ask Brien on that.

MR. FALAHEE: Okay.

MR. HECKMAN: I mean -- so Assistant Attorney General Brien Heckman. You can put the formalities on a workgroup that you want. It would just be part of a charge.

MR. WIRTH: And the workgroup process also allows the chairperson to set -- they get to determine how they want to run the workgroup. If they want to abide by a modified Robert's Rules like we do here on the Commission, they can run the workgroup that way if they wish. That's within the chair of the workgroup's purview as well.

DR. MCKENZIE: This is Commissioner McKenzie. Would that apply as well to an ability to designate votes that are in block or -- like, because that's also what I heard is this piece of stacking the deck, you know, where

you get a vote for, you know, facilities and create some sort of balance within that.

MR. WIRTH: So, I mean, workgroups -- they work through a consensus of the group. The tallying of votes is -- will do that if it's a close call, but then that's brought back to the Commission for the Commission to decide whether or not to move forward with that recommendation or not. So it would -- if there's a disagreement on a charge, it would be reported back to the Commission as a non-consensus item, but here's how the vote looked.

DR. MCKENZIE: Okay. I have one more clarification question for you. I know that we have already decided on a SAC for Cardiac Cath. You said that you can manage two a year. Can you remind me what the other standard is that we are -- that the Department has recommended a SAC for this year?

MR. WIRTH: We're anticipating Surgical Services needing a SAC and that will be later in this meeting.

DR. MCKENZIE: And the reason for a SAC for Surgical Services is because of the complexity or the number of charges?

MR. WIRTH: Both.

DR. MCKENZIE: Thank you.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch. A question. I'm hearing a concern

about managing multiple SACs at once and the bandwidth to do that as well as the timing on a SAC or seating a SAC. Has there ever been any precedent where there has been three SACs at a time? Because I feel like that's not necessarily a good reason to, like, abandon what would otherwise be, like, the preferred process. I know the outcome we're saying could be the same or similar, but that process and the individuals involved in that process to get there is very different. So I just am concerned given the highly technical methodology that goes into the Hospital Bed calculation and all the identified issues here and the timing with the -- you know, the comments and the politically charged nature that a workgroup might open us up to some challenges. So I just, I think if we have historical precedent for doing a SAC with hospital Beds that now might not be the best time or make the most sense to change that. So I guess I would ask the Department if we've ever done three SACs and if you think that's doable? I just don't want to see us cut a corner to make it easier. I'm not saying that's what we're suggesting, but --

MS. NAGEL: Yeah. So that is essentially just our recommendation and the Commission can certainly make the decision to do something different than what we have recommended.

DR. ENGELHARDT-KALBFLEISCH: Yeah.

MS. NAGEL: Typically we try to limit the number of SACs in one year so that we can give adequate attention to each body that comes together. Not only that, but -- I hope that wasn't me -- but time and space as well are considerations. We can certainly -- if this Commission decides to do a SAC, we will make it work.

DR. ENGELHARDT-KALBFLEISCH: Okay.

MS. NAGEL: Now, that may mean that some of our work -- and what has happened in the past when we've had more than two SACs in a year and why we try to confine it to two, is that that work tends to slip into the next year then. And if the Commission is okay with that as a potential consequence, then I think we're okay with that as a potential consequence. Really as Commissioner Falahee said, it really does take a lot of time to seat a SAC and so it then kind of stacks up. Do you know what I mean?

DR. ENGELHARDT-KALBFLEISCH: Yeah; yup.

MS. NAGEL: And so that's really our main concern is to be efficient and effective to bring things back to you. So if you understand that that's a consequence, then we'll act accordingly.

MR. HANEY: Comment and a question. Commissioner Haney. So my first comment of hearing your concern about slipping into the next year is -- you know, we've already heard Psych Beds being an immediate crisis issue and this

issue is emergent and of concern. So that's my comment. It's a concern about time. My second comment is currently working on a long-term care workgroup, what I have seen is a fairly consistent participation, 25 to 30 folks, usually the same folks every time. What I don't know, because this is one experience on a workgroup, is is that fairly consistent for workgroups? We talked about the possibility of why the varying workgroup from meeting to meeting, but has that been the experience from the Department of actually seeing that and then the stacking of votes at the end. There's possibility, then there's probability. So has that happened? Is that common?

MR. WIRTH: I'd look to Beth since I'm relatively new to CON. All things considered, it's been around awhile.

MS. NAGEL: I have seen it go both ways to be honest. I'm thinking of one particular issue where everybody from a particular type of specialty came and sat in a room and it was a huge room stacked with this particular specialty so that they could vote very specifically on one issue and then we never saw those people again. So that has happened once that I can recall. You know, to Kenny's point earlier and probably what you've seen is that most of the workgroups do kind of go with consensus and the reports that you get back at the Commission say "the group had consensus on these four things but not on these

two things," and I can recall we've given you lists of who voted on each item, you know, so that the Commission can kind of evaluate what this a situation that, you know, was a -- you know, kind of a for and against kind of issue. So, you know, I guess I don't have a great answer for you. I have seen both. I haven't seen the issue -- the one issue of kind of stacking the deck, I've seen that in particular one time that stands out.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch. Could we -- so we don't know if the Surgical Services issue will go to SAC or not, but if it does, like, I'm hearing the timing and that that's a priority for, I think, all of the commissioners. Is there a way we could say if we did do a SAC, that we would seat this first to help address that timing issue so that we could make sure it's priority?

MS. NAGEL: Yeah. Certainly we would prefer that the Commission actually does give us our priorities moving forward.

DR. ENGELHARDT-KALBFLEISCH: Okay.

MR. FALAHEE: And that easily done because we could say, all right, let's start working on this one first. Let's say it's Hospital Beds.

DR. ENGELHARDT-KALBFLEISCH: Sure.

MR. FALAHEE: In the past there has not been a

problem seating SAC members -- I got to say that slowly -- on a Hospital Bed SAC. Okay? So I don't anticipate any problems with that. I already have a potential chairperson in mind. So that should not be a problem. The other -- the only -- and I'm fine with a SAC. All right? I understand exactly where Beth is coming from. It may slow things down, but there's specificity in how it operates. The only disadvantage is with a SAC it's subject to the Open Meetings Act. So you got to be in person somewhere and it's usually in Lansing because Lansing has some -- so if there are other people on that SAC that are from far northern Michigan that have issues about hospitals, it may be difficult for them to be here but that's just -- that's neither here nor there in terms of the ultimate decision. That's just another factor. But I can easily work with the Department if the Commission so chooses along with Vice Chair McKenzie, "Okay, we're going to seat the Hospital Bed SAC first. Let's get going."

DR. MCKENZIE: Yeah, Commissioner McKenzie. One additional comment I would add as to -- you know, and I mean pros and cons; right? The lack of virtual nature I think is a big con. A pro is that with a SAC you are -- they have a time limited window once they're seated, too. We will have a recommendation back within six months whereas a workgroup is more open-ended. So I think there are some benefits to it as well. So nothing is perfect.

MR. FALAHEE: Other discussion?

DR. MACALLISTER: Commissioner Macallister. I remember we just mentioned that you could also put those provisions in the workgroup for if we wanted time bound or whatnot as well. I'm wondering as well if we determined today to do a SAC, could we -- if we weren't getting it seated as quickly as we would like, could we convert that at the next meeting or after if we're seeing no movement?

MR. FALAHEE: Yes, I think we could because next meeting is March 15th, 16th, something like that. By then we'll know -- I think -- and, Beth or Kenny, I'll turn to you. Okay, two months, we'd be able to put the nomination out there in the public and get people to nominate themselves and potentially get a chair and vice chair within that two-month period, if not shortly after that?

DR. MACALLISTER: Right. We would -- we would at least know that --

MR. FALAHEE: We'd have a sense then.

DR. MACALLISTER: Yeah.

MR. FALAHEE: Right. Other comments? Go ahead.

MS. TURNER-BAILEY: My comment probably can't be answered today, but I -- but I would like to hear from the Department and others, recommendations around when we would seat a SAC and when we would seat a workgroup. Because I feel like it's a little bit -- you know, we're a little ad

hoc about the decisions and I think it would be helpful if we all knew, you know, if there's -- I don't know what the criteria would be, you know, if there's certain amount of number of charges, if it's the urgency, you know, what those -- what those criteria might be. But maybe if we had a little bit more guidance around when we would seat a SAC versus a workgroup, you know? Been around CON for a long time and the workgroup concept is new -- is kind of new to me and I like the idea of a SAC for the reasons that we have discussed; the fact that we already know, you know, who's going to be represented. We make sure we have, you know, a great representation from professionals but also from a layperson's perspective. And I believe that that's really important for all the issues that we're dealing with. So I'm just -- I just want to make that suggestion. Maybe it's something that can -- we can talk about in the March meeting. It, you know, obviously can't be solved today but I would like to feel a little bit more strict -- a strict nature around making those decisions.

MR. FALAHEE: I will say -- this is Falahee -- from prior experience we have always seated a SAC when we have people on one side or the other and there's -- and professional, reasonable minds can differ. And there one instance -- you weren't on the Commission then -- we had three doctors testify that, "yes, we should do this," then

we had three more doctors that say "no, we should not do this." That's the perfect setup for a SAC. And I then took the leaders of each of the three and, "see, you are now the chair and the vice chair of the SAC. Congratulations. Work it out." So that's one of the ones where we look at it. But I think your idea is a good one instead of an ad hoc basis. I think that's true. Commissioner Haney?

MR. HANEY: Yeah, just one more question on the workgroup process. Just as we -- if we can put time limits on it and kind of mimic the SAC from the standpoint, can we also put a constraint that those that vote on the end product or the end solutions have attended at least 50 percent of the meetings or 75 percent meetings or would that be left to the chair of the workgroup or --

MR. HECKMAN: So the more technical requirements you put on it the more problematic all of that becomes. So a durational requirement is pretty straightforward. But I think beyond some of those requirements, duration, perhaps just an indication as to the composition of the workgroup and once you get beyond that you start getting into we should sit a SAC for the matter.

MR. FALAHEE: Other discussion? Great discussion. Okay. So where we're at is that there are charges in front of us. I didn't hear any of the witnesses talk about adding to or subtracting from the charges in front of us. The

question I think is whether it should be a SAC or a workgroup. You can go back and forth. I could either -- argue either one. But I think the way to resolve it is for someone to make a motion and we'll see where it goes. So I would entertain -- oh, one more. Commiss- --

DR. ENGELHARDT-KALBFLEISCH: Oh, nope. I was just going to make a motion.

MR. FALAHEE: Okay. Great. Thank you.

DR. ENGELHARDT-KALBFLEISCH: I'll let you finish.

MR. FALAHEE: No; no. That's great. Thank you. Go ahead.

DR. ENGELHARDT-KALBFLEISCH: All right. So Commissioner Engelhardt-Kalbfleisch. I move that we accept the Department's recommendations for the issues to be reviewed within the Hospital Bed standards, but, rather than a workgroup, we form a SAC to review the charges outlined as the Department has recommended.

DR. FERGUSON: Ferguson, second.

MR. FALAHEE: Motion on the floor. Discussion? May I ask for a friend- -- let me see if you'd be willing to -- for a friendly amendment to that motion. That would say that the charge may be drafted and voted on by the Commission or the Commission can instruct the chairperson to write the charge consistent with the language adopted by the Commission. If you look at what we just did for Cardiac

Cath Services, you can see where I'm coming from on this one.

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. FALAHEE: And that the term of the SAC will expire six months after the first meeting of the SAC unless we as a Commission specify an earlier date, and that the chair will appoint -- the chair of the Commission will appoint the members of the SAC consistent with statutory requirements and the Commission bylaws, and further the chair will appoint the chairperson of the SAC. A friendly amendment to the motion.

DR. ENGELHARDT-KALBFLEISCH: Agree with the friendly amendment.

DR. FERGUSON: (indicating)

MR. FALAHEE: Okay. So does Commissioner Ferguson. Sorry.

DR. FERGUSON: Absolutely.

MR. FALAHEE: It's the details.

DR. ENGELHARDT-KALBFLEISCH: No, thank you for the details.

MR. FALAHEE: Well, no, it's otherwise I'm going to get stares from the Department and from the gentleman sitting to my right.

DR. ENGELHARDT-KALBFLEISCH: The details are important. Thank you.

MR. FALAHEE: So we have that motion as with a friendly supplement to it on the floor. All those in favor of the motion please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Okay. All those opposed to the motion raise your hand. All right. That motion carries.

(Whereupon motion passed at 12:25 p.m.)

MR. FALAHEE: A SAC will be created. Thank you, everyone, for your discussion. Mr. Curtis and friends, I can't see all of you, but thank you for being here. Look forward to your participation.

MR. JACK CURTIS: If you need anything, call. We're on our way back.

MR. FALAHEE: Okay. Next -- I'll give Kenny a chance to catch up if he needs to. Next MRT Services. And, Kenny, I'll give you a chance to summarize everything as you'd like or Kate? Are you going to do that? I don't know.

MS. TOSTO: So for MRT Services and Units, public comment period was held from October 7th through October 21st of 2022. We received comments from four organizations and a summary of these as well as the comment letters are included in your binders. All comments received are in support of continued regulation of MRT Units and Services and the Department is recommending a workgroup to consider

several items identified in testimonies. The Department supports the recommendations to review considering provisions related to initiation of new MRT Services in HSA 8 to address rural access areas; the review of all weights, additive values and associated definitions in order to address new technologies used for MRT treatment and other technical edits by the Department if needed. If a workgroup is to be seated, then a written charge will need to be drafted and voted on by the Commission or the Commission may instruct the chair to write the charge consistent with the language presented to these meetings. The chairperson would also appoint a chairperson and vice chairperson for the workgroup. After the workgroup completes its work, it would then bring its recommendations to the Commission at a future meeting.

MR. FALAHEE: Thank you very much. Any questions of Kate? Okay. Public comment cards? I don't know if we have any or not.

MR. WIRTH: Yes. I have one from Patrick O'Donovan, Corewell.

PATRICK O'DONOVAN

MR. PATRICK O'DONOVAN: Good afternoon, Commissioners. My name is Patrick O'Donovan. I'm here on behalf of Corewell Health. I would like to comment on U of M's last minute request for the Commission to form an MRT

SAC to review the CON requirements for HMRT --

(Off the record interruption)

MR. PATRICK O'DONOVAN: -- or proton beam therapy services. We do not believe such a SAC should be formed at this time for a couple of reasons. First, public comments on MRT and all the services up for review were due last October. Waiting until now to request a SAC of this charge does not allow sufficient time for the Commission or other interested parties to review and react to the claims made in their letter. For example, had we known that -- about this request in advance, our radiology oncology chairman might have been able to attend today's meeting to engage in the discussion. As it is, he is out of the country with very limited access to e-mail. I did text him some page photos of the letter and he made a few comments. First, Beaumont's proton center will be able to treat eye cancers when our rotational proton process is installed later this year or early next. Our proton center can and does receive referrals from U of M for children. There's no reason U of M's pediatric proton referrals must leave the state and we also provide housing for children undergoing treatment if needed. Our proton service is highly utilized, but we are still accepting referrals and once our rotational process is installed, capacity will increase by approximately 25 percent. In addition, and I don't want to speak for the

Department, but it's pretty apparent with the discussion today, by my count the Department is already going to be supporting three SACs and two workgroups as a result of today's meeting. It's unlikely the Department has the capacity to add another SAC to the work plan and we don't believe this last minute request should take priority over the other SACs and workgroups being recommended. Thank you for your time. Be happy to answer any questions.

MR. FALAHEE: Questions?

DR. FERGUSON: Question either for you or for the Department. So I don't understand all the rules at this point around proton beam therapy. Is that specifically called out and addressed in the existing guidelines?

MS. NAGEL: (Nodding head in affirmative)

DR. FERGUSON: It is. Yeah. Okay. Thanks.

MR. FALAHEE: From a historical perspective, some of this room were around when we were doing the proton beam battles and I was one of them and it specifically called out and it took a long time to put it together. I'll leave it at that. A question I got for the Department -- well, first, Patrick, you mentioned a SAC. The Department's recommending a workgroup here.

MR. PATRICK O'DONOVAN: Well, I thought in the letter -- the letter recommended a SAC that U of M wrote.

MR. FALAHEE: Oh, okay. Got it. All right.

Okay. Question for the Department to Mr. O'Donovan's comment that this University of Michigan comment was late. Is there a timeline by which comments must be made and if they're made after that timeline they're not subject to our review? I don't know.

MR. WIRTH: We normally request things be sent in a week before the meeting so we can work it into the packet and get it out to you on time. We send out our, you know, revised packet Tuesday before the meeting so I don't know that we have a firm, set deadline but we try to get everything to the Commission what we can if it comes in late.

MR. FALAHEE: But there's nothing in there that says though we open it up in October, everything must be submitted by December 31st?

MR. WIRTH: Well, we do have a close date for the public comment period. This letter came after that, I believe, and we included it as public comment for this meeting.

MR. PATRICK O'DONOVAN: I think the point is if this was a position and it had been brought forward during the proper time, then others who might have comments might have an opportunity to make arrangements to come and make -- you know, make comments. So it wasn't from a -- you know, anything in the statute or when it can or cannot be. The

Commission always has that prerogative.

MR. FALAHEE: Okay. All right. Other discussion or questions? Let me ask Mr. O'Donovan. What if we said, well, all right, if we put it into the workgroup, not a SAC, the workgroup, that issue about proton beam -- and I understand where U of M is coming from, I know where Beaumont's coming from -- and just say, all right, let's discuss it within the workgroup, what's your reaction to that?

MR. PATRICK O'DONOVAN: Obviously that's the prerogative of the CON Commission. It might be fairly difficult to achieve a consensus whereas in a SAC, you know, you -- it might be messy, but you have an answer at the end and you may not get that with the workgroup, but that's the Commission's prerogative.

MR. FALAHEE: Thank you. Other questions? Okay. Thank you.

MR. PATRICK O'DONOVAN: Thank you.

MR. WIRTH: No other comments.

MR. FALAHEE: No other comments? Okay. Commission discussion?

DR. FERGUSON: I guess I don't have a problem adding a workgroup and having that workgroup look at proton beam and if they come to common ground, they do and if they don't, it doesn't -- we actually have to do anything with

it. I don't think having dialogue is a bad thing.

MR. FALAHEE: Other comments?

DR. MACALLISTER: Chairperson, Commissioner Macallister. You mentioned before that it was very contentious in regards to the development of the initial and so, again, just as we mentioned about the SAC, how things when you have adverse sides that it may be a concern that we would open ourselves up to greater need for revisions or kind of --

MR. FALAHEE: Yeah, you're right but this one is a little bit I think different. With the proton beam battle -- and I didn't keep -- the facility I'm at, Bronson, we don't have a proton beam. We don't have one. Corewell -- what do we call it? -- Corewell West doesn't have one either. So I know they're on the east side of the state and I think there are two?

MS. GUIDO-ALLEN: Two.

MR. FALAHEE: Two. Right.

MS. GUIDO-ALLEN: Flint -- Flint and Royal Oak.

MR. FALAHEE: McLaren and Beaumont; right? Okay. So I think it'd be -- it'd be good to at least have the workgroup discuss it for the discussion. To Commissioner Ferguson's point, I think it's worth it to have the discussion. There may be a report that comes back to us and says we had the discussion and we can't agree, but at least

we tee up the issue; i.e. the issues of -- I'm sorry. I'll finish. The issues of Mr. O'Donovan talked about part of it, is there a patient access issue currently? Can patients that need care get in, into the two facilities that are in existence now? I don't know. We hear there's capacity. There's theoretically 25 percent more capacity coming to Beaumont site. I think that's something a workgroup could look at. Do we have patient access issues? You know, I think that's something that's worth a discussion within the workgroup.

DR. MCKENZIE: This is Commissioner McKenzie. And I would agree with both Commissioner Ferguson and Commissioner Falahee on this one. That I think the dialogue is beneficial. You know, we've had things come back from a workgroup before where we didn't get agreement and we pulled that charge back out and decided we're going to kick this down further or we've got to form a SAC now because there's, you know, not agreement. So, you know, I think it might provide some enlightenment for this group. I know that, you know, the reasons for proton beam have expanded in terms of what we pay as a payer and so I don't know, are there access issues, you know? So I don't think it's bad to have a dialogue and look at it and get more information and then determine what we want to do.

MS. GUIDO-ALLEN: Guido-Allen. It could also be

educational in the sense that what does proton treat and what, you know, photon can treat. It's not apples to apples. It's not you can do one or the other. It's very specific as to the treatment and the diagnoses that they can treat.

MR. FALAHEE: Any other discussion? Would anyone care to make a motion?

DR. FERGUSON: I'll move that we seat a workgroup to address the Department identified topics already delineated and add to that charge the regulations around proton beam therapy as well, plus whatever friendly amendments you'd care to add.

MR. FALAHEE: Is there support for that motion?

DR. MCKENZIE: I'll second the motion.

MR. FALAHEE: I don't have any friendly amendments. I think you stated it well. Any discussion? All in favor of the motion please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Anyone opposed to the motion? Okay. That motion carries. Thank you all.

(Whereupon motion passed at 12:37 p.m.)

MR. WIRTH: And, I'm sorry, Commissioner Ferguson, did you say "proton" or "photon"?

DR. FERGUSON: "Proton."

MR. WIRTH: Proton. Thank you. I just wanted to

make sure I had that right.

MR. FALAHEE: We don't want to get into the photon. All right. Moving forward. It's always good when we move to the second page of our agenda. Roman numeral IX, Open Heart Surgery Services. And I don't -- okay, Kenny?

MR. WIRTH: I can take this one. And, yeah, Kate had to run to start another council meeting that we're running today that starts at 1:00, so we will be joining her after this. So for Open Heart we held an October 7th through October 21st public comment period. We received comments from three organizations. The summary of these as well as the comment letters are included in the binder. All comments received are in support of continued regulation of Open Heart Surgery Services. The Department is recommending a workgroup to look at some technical edits in an item identified by CON. These include reviewing Section 8(4)(3) to address reporting compliance for hospitals with lower than one STS AVR star rating and other technical edits by the Department if needed. So if a workgroup is to be seated, then a written charge will need to be drafted and voted on by the Commission, or the Commission may instruct the chair to write the charge consisted with the language presented at today's meeting. The chairperson would also appoint a chairperson and vice chairperson for the workgroup. After the workgroup completes its work, it would

then bring its recommendations to the Commission at a future meeting. And I don't have any public comment on this one.

MR. FALAHEE: Commission discussion? Questions of Kenny or the Department? Any other discussion items?

DR. MCKENZIE: I can make a motion to move forward with seating a workgroup for the items that are outlined and allow the draft of the charges, delegate it to the chair, and selection of the chair and vice chair of the workgroup (inaudible).

MR. FALAHEE: Support for that motion?

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch. Support.

MR. FALAHEE: Thank you. Any discussion? All in favor of the motion please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Anyone opposed? That motion carries.

(Whereupon motion passed at 12:40 p.m.)

MR. FALAHEE: I'm going to go back a little bit to the MRT motion. I didn't -- I said I didn't have any friendly amendments because I assumed when Commissioner Ferguson made it and the motion was seconded, that we talked about the charge be drafted and voted on by the Commission, the Commission may instruct the chair of the CON Commission to write the charge consistent with what's adopted by the

Commission and that the chair will appoint the chair and vice chair of the workgroup. I'm assuming --

DR. FERGUSON: That was in there in a mumble somewhere.

MR. FALAHEE: I'm just making sure we have a record of it so we're all set. Thank you very much. Thank you for keeping me straight, Don.

MR. HANEY: Yes; right.

MR. FALAHEE: Okay. Next, PET Services. PET Services.

MR. WIRTH: Yes. So this was part of our public comment period held from October 7th to October 21st of 2022. We received testimony from seven organizations. All organizations along with the Department support continued regulation of PET Services. The Department is recommending that the Commission charge the Department with making one technical edit related to a planned decrease and/or discontinuation of services, but no substantive changes are being recommended. And the Department can draft this language for review and proposed action by the CON Commission. And I don't have any comments on this one either.

MR. FALAHEE: Questions? Comments? Kenny, do you need a motion from the Commission to have you go do that technical edit?

MR. WIRTH: Yeah, it would be a motion to charge the Department with making that change and bringing forward language at a future meeting.

MR. FALAHEE: Would anyone care to make that motion?

DR. MCKENZIE: I'll move to direct the Department to make the necessary changes to the language and bring those back to the Commission for review.

MR. FALAHEE: Support?

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch. Support.

MR. FALAHEE: Thank you. Any discussion? All in favor say "aye" or raise your hand. I'm sorry. Sorry about that.

ALL: (all raise hand).

MR. FALAHEE: Any opposed? Okay. We're set. Great.

(Whereupon motion passed at 12:42 p.m.)

MR. WIRTH: So McKenzie moved, Engelhardt second?

MR. FALAHEE: Yup. Sorry, Kenny, for that when we moved quickly.

MR. WIRTH: Well, buckle back in for our next one.

MR. FALAHEE: All right. Next, Surgical Services, so I will turn it over to Mr. Wirth to explain where we are.

MR. WIRTH: Yes. So the public comment period was

held from October 7th through October 21st of 2022. We received comments from six organizations. All organizations along with the Department support continued regulation of PET Services. The summary of these comments and the comment letters received are included in the electronic binder. The Department is recommending that the Commission form a Standard Advisory Committee to review some of the items brought forward. These include reviewing the ownership and volume requirements for applicants proposing to relocate an existing service or operating room in Section 5(6); reviewing the volume requirements for ambulatory surgical centers to accept dialysis access procedures performed in office-based labs; reviewing the volume requirements to protect access to surgical services provided by rural hospitals; revising the definitions for "ambulatory surgical center," "freestanding surgical outpatient facilities," "procedure room" and "surgical case"; revising Section 6(1)(a) to clarify expansion volume requirements; revise Section 6(1)(b) to include existing operating rooms; revise Section 9 to clarify that an individual physician's Medicaid enrollment is not sufficient for the facility's Medicaid enrollment; clarify what is considered "reasonable" when reviewing projections under Section 11; reviewing the addition of language to improve access to Surgical Services in rural or micropolitan counties; and other technical edits

by the Department if needed.

If a Standard Advisory Committee is to be seated, then a written charge will need to be drafted and voted on by the Commission, or the Commission may instruct the chair to write the charge consistent with the language presented at today's meeting. The term of the SAC would expire six months from the first meeting of the SAC unless the Commission specifies an earlier date, and the Commission chairperson would appoint the SAC members consistent with the statutory requirements and the CON Commission bylaws. The chairperson would also appoint the chairperson for the SAC. After the SAC completes its work, the SAC chairperson would then bring the SAC's recommendations to the Commission at a future meeting.

MR. FALAHEE: Kenny, in the summary -- and we've got -- there was another bullet point about restructuring Section 5 to improve clarity around the requirements and I didn't hear you say that. But is that still part of the proposed charge?

MR. WIRTH: Yup. Sorry. My bad. Yup.

MR. FALAHEE: Oh, that's all right. Okay. I didn't know if there was a late breaking development that we -- okay. All right. Any questions of Kenny on where we're at right now? Okay. Public comment? I'm assuming you've got some cards on this one? Just a wild guess.

MR. WIRTH: Yes, I do. First we'll go to Amy Barkholz, MHA.

AMY BARKHOLZ

MS. AMY BARKHOLZ: Good afternoon. Thank you members of the Commission. I'm Amy Barkholz, general counsel for the Michigan Health and Hospital Association, and I am up here to support the Department's recommendation to form a SAC to look at the Surgical Services standards. Particularly from the MHA's point of view, I wanted to support the provision in the charge to look at how we look at Section 11 as it applies to rural and micropolitan communities. This is the section that talks about documenting projections of volume based on the written commitments of surgeons that pledge to transfer their surgical cases from one facility to another within a 20-mile radius.

MHA represents all of Michigan's 132 community hospitals in the state. And what we are hearing lately, especially from some of our smaller and mid-size communities, is that there's been a lot of recent growth in for-profit, freestanding specialty surgery centers in these smaller communities, but there's not really corresponding growth in the actual new numbers of surgeries. So the current standards are permitting surgeons to pledge to transfer the so-called excess surgical volume to proposed

new facilities when there's not actually sufficient extra volume to pledge. So the cases that are being transferred are, as you would expect, less complicated, the prescheduled specialty surgeries and then that's leaving the already struggling community hospitals at a further disadvantage to meet the total care needs of the community. And in larger communities, you know, there's certainly absolutely a place in the care continuum for freestanding surgery, specialty surgery facilities, but in these smaller communities we're seeing that it's a struggle and we think that there could be some tweaks to the language that would really get at whether there's really the excess capacity to support those type of specialty facilities or whether it's really going to burden the community hospital and leave the communities with a big access problem. So we really support this charge. That's essentially my comments. Thank you.

MR. FALAHEE: Any questions? Thank you.

MR. WIRTH: Next I have Dr. Vidooshi Maru of the Nephrology Associates of Michigan.

VIDOOSHI MARU, M.D.

DR. VIDOOSHI MARU: I'm short. Sorry. All right. Members of the Commission and the Department, my name is Vidooshi Maru. I am a nephrologist who provides specialized care to patients with kidney disease including those who need dialysis which is a form of kidney replacement therapy.

I've been in practice for almost 15 years since completing my nephrology fellowship at the University of Michigan. I'm here today representing Nephrology Associates of Michigan and our patients. We are an independent practice providing care for over 1,000 late stage chronic kidney disease patients and 8- to 900 ESRD or dialysis patients. We also operate the Dialysis Access Center of Southeast Michigan which is a fully licensed and accredited facility that cares for the access needs of these dialysis patients. It's categorized as an office-based lab or an OBL as you may know it. Dialysis patients are a vulnerable patient population. To say that they have complex health care needs is quite an understatement. Further, ERSD status automatically qualifies a patient for Medicare, making Medicare the largest payer we service at the access center and we expect the patient volume in this arena to continue to grow. Accesses are the conduits that we use to facilitate dialysis treatment. These include catheters which are lower quality accesses and arterial venous fistulas and grafts which are our preferred options. Missing dialysis treatments due to access failure leads to higher morbidity and mortality. If a patient goes to dialysis and their access does not support the treatment, we are able to get that patient in the same day to our access center where interventions are performed from where we then send them back to their dialysis clinics

to get their treatments. There's minimal disruption. There are no missed or shortened treatments. We consider these lifesaving services a mainstay of the chronic disease management that comes with managing a large ESRD population.

The Dobson study that you have in your packets confirmed that the best setting in which to receive these services are our outpatient vascular access centers. Currently our OBL provides standard of care for our patients and represents best practices in our field. However, CMS considers ASCs to now be the best and most appropriate site of care for these procedures. CMS is steadily cutting reimbursements for the procedures, reduced simply because they are done in an OBL. And in the next few years we'll need to make some difficult decisions regarding the solvency of our centers and the services that we can provide. Shuttering it means loss of access, lower quality -- yeah.

MR. WIRTH: Your three minutes, so if you want to wrap up?

DR. VIDOOSHI MARU: Oh. Oh, wait. Loss of access, lower quality and higher cost of care for all these patients. We have exhausted all avenues in trying to convert our center to an ASC locally.

Our ask of you is to accept the Department's recommendations for a SAC to allow us to convert our -- allow us to commit our office-based lab cases to our

application to -- see, I'm going off script, sorry -- to our CON -- to allow us to commit our cases to an application for an ASC.

MR. WIRTH: Thank you.

DR. VIDOOSHI MARU: Okay. Thank you. Sorry.

MR. FALAHEE: That's all right.

DR. VIDOOSHI MARU: Three minutes is tough. I cut out a lot.

MR. FALAHEE: Well, that's why -- we do it for everybody. So thank you very much. Let me ask Kenny a question. I think one of the proposed charges you've got in here is review volume requirements for ASC to accept dialysis access procedures performed in office-based labs. Is that this issue?

MR. WIRTH: Yup.

MR. FALAHEE: Okay. You agree with that, Doctor?

DR. VIDOOSHI MARU: Can I clarify, though? It's not the volume. We do 1500 cases a year at our access center so we have no problem with the volume. The issue is really the site. So we can't commit cases from a non-licensed OR, which our facility is not currently a non-licensed -- is not in a licensed OR. So we would like to commit our cases from an office-based lab towards our application for a CON for an ASC.

MR. FALAHEE: Is that part of this charge?

MR. WIRTH: We'd be open to the dialogue in a SAC. So, yes, for the charge we'd be open to that being discussed. We wouldn't -- I don't think we'd want to revise what a surgical case is, but we're open to having the SAC explore this issue or topic to --

MR. FALAHEE: SAC or workgroup?

MR. WIRTH: SAC.

MR. FALAHEE: Or workgroup?

MR. WIRTH: Or workgroup if you prefer a workgroup.

MR. FALAHEE: Just leaving it out there. Okay. But whether whatever it is, you'd be willing to look at the issue?

DR. MCKENZIE: Yup.

DR. MCKENZIE: Can I ask about --

MS. GUIDO-ALLEN: I have a question, too.

DR. MCKENZIE: Is that definition imbedded within this Surgical standard for what has to be committed and tied to the ability -- for the application for an ASC? Have I understood that correctly? Or does that exist somewhere else? Because what I'm asking, I guess, is does this solve -- does this discussion solve the issue that we just heard or does that exist or reside somewhere else?

MS. BHATTACHARYA: This is Tulika. So I'll have to admit I was not involved in this ESRD/ASC discussion,

but, Dr. McKenzie, what I can tell you how the Department interprets the current Surgical standards and what definitions are. So right now the process to start a new FSOF or ASC is by commitment of excess surgical cases and a surgical case in the CON standard is defined as a case that is done in a licensed hospital, licensed FSOF or licensed ASC. So CON, Certificate of Need does not regulate dialysis center and those are not categorized as a "licensed facility," so the procedures that are being done in the ESRD facilities do not qualify as a surgical case and, therefore, cannot be committed currently to start a new FSOF or ASC.

DR. MCKENZIE: Okay. So follow-up question to that. That definition is imbedded within the Surgical CON standards so there is the ability to have this discussion and potentially create a different recommendation?

MS. BHATTACHARYA: (indicating)

DR. MCKENZIE: Okay. Okay.

MS. GUIDO-ALLEN: So can I -- Guido-Allen.

DR. MCKENZIE: Not saying that we should. I just -- I just wanted to understand if there was --

MR. FALAHEE: Yeah.

MS. GUIDO-ALLEN: -- so if it's decided that these cases -- and not just access cases because a lot of OBLs are vascular procedures -- are we going to be then labeling OBLs that meet a volume requirement as an ASC, which I think is a

slippery slope? A really slippery slope. Just my own opinion.

DR. VIDOOSHI MARU: So can I answer? Can I answer that?

MS. GUIDO-ALLEN: Yeah.

DR. VIDOOSHI MARU: I totally understand the slippery slope argument. What I would like to point out is that other patients currently have standard of care, access to care in other settings and our patients currently do not. So if we do not provide these services, they go to the hospital and the hospital is diminished access to care, poor quality in terms of access management, what we try to do long-term for patients, and then also total cost of care. And I was rounding over the holiday and had a patient come to the ER Friday from another practice. They got admitted because their access didn't work. We put the consult in for radiology and for vascular to see them. They didn't get seen until Saturday afternoon. They had a catheter placed instead of their fistula work done and we were told, "Well, we can work on that on Tuesday when we open back up to general business" which is a five-day hospital stay for a dialysis patient over a holiday. Right? So I think that we can narrowly state the language. So, you know, our patients kind of fill a unique bucket that nobody else really fits into and if there's a way to meet their needs without kind

of opening the floodgates for everybody else, I think that that's possible.

DR. KONDUR: Commissioner Kondur. And I agree with Commissioner Guido-Allen, it's a little bit slippery path. The vascular access cases, even done in the nephrology standpoint or cardiology or vascular, if you can reduce cases is like surgical cases would apply for the ASC and this would open up a lot of controversies.

DR. VIDOOSHI MARU: We do have sample language in your packets that would limit this really to just dialysis patient vascular access. And, again, CMS's goal is to keep our patients out of the hospital as much as possible because their comorbids lead to all kinds of complications and lengthy hospital stays. We are able to get our patients in for same-day services that we would not be able to do otherwise in any other setting and that's what keeps them getting their dialysis treatment, that's what keeps them out of the hospital, that's what keeps them healthy and at home. We are happy to entertain any other solutions that you might be able to suggest for us. This was what we kind of felt was the simplest verbiage.

DR. FERGUSON: So this is Ferguson. This is real existing volume, real procedures, right, so it's not made up volume. It's not double counting volume. It's not pledging volume twice. It's not inventing volume. These are

patients who are having the procedures done. There's got to be some mechanism that allows us to manage that. And I understand the slippery slope, but I think we have to be cautious about it and we're not trying to open the floodgates or whatever. But one way or another the patients deserve the care that they're getting already. Right? So, again, I defer largely to the Department on how to manage this because I know we have definitions that are built in around, you know, what's a surgical case that's pledgeable. But I would encourage some creative thought around are there ways to footnote some exceptions or other existing case volume within certain confines or something. Again, I don't know what the answer is other than it's real case volume.

MS. GUIDO-ALLEN: I have another -- I'm sorry, another question. In your statement you stated that CMS is decreasing your reimbursement for these procedures unless you're an ASC?

DR. VIDOOSHI MARU: Yes.

MS. GUIDO-ALLEN: So they are promoting the fact that you keep the patients out of the hospital, et cetera.

DR. VIDOOSHI MARU: So they want --

MS. GUIDO-ALLEN: So help me understand that.

DR. VIDOOSHI MARU: -- so they want -- and my colleague Linda will speak a little bit more to that, too. But they want us to move our cases to an ASC. So in an

office-based lab, quality reporting, for example, is optional. In an ASC it's mandatory and there are certain standards to be met and they also look at ASCs as a means of controlling cost. So they're trying to incentivize everyone to move other outpatient surgical cases to an ASC. Unfortunately, that really hurts this specific population. Because of the standards in place, we're not able to easily do that for them, but I think that's the rationale. So the cuts have been coming and coming and coming. It's not an insignificant thing to convert to an ASC. We have sort of been fine treading water, but we're looking ahead and this is going to become a big problem for us in the next few years.

DR. MCKENZIE: And, Doctor, I do have a follow-up question. This might have been imbedded in your comments that you didn't get to, but -- and I'm going to get quickly over my skis. I'm a family physician. So, but my -- my understanding -- and if you could speak to -- you gave an example of, like, patient gets in the hospital, they have a catheter put in, they have to wait until Tuesday to get their more permanent kind of fistula put in. Can you speak to what's going on in the quality space around that for these patients of a catheter versus an earlier fistula placement and if there's any differences with that in terms of risks?

DR. VIDOOSHI MARU: Oh, there's lots of differences.

DR. MCKENZIE: So could you speak to that and educate us a little bit about that?

DR. VIDOOSHI MARU: Sure; yeah. So not all dialysis accesses are created equal. Catheters are a piece of plastic that get imbedded into your chest. When we do -- when we are looking at accesses, we're looking at a way to pull blood out of your body, run it through the machine to clean it, put it back. It's a continuous circuit, a dialysis. So catheters cause a lot of vessel trauma. They're high infection risk. They don't work well. They require lots of changes. Fistulas and grafts are conduits that are surgically placed under your skin, typically in your arm. We cannulate them with needles at dialysis and then when we are complete -- when the treatment is completed we pull the needles and hold pressure. Those fistulas and grafts offer much lower rates of infection and complication. So they are the gold standard for how we should be managing our dialysis patients. There are a lot of quality incentives coming out of CMMI to help move patients to that. So if you have a CKD which is a chronic kidney disease patient who you know is heading for dialysis, there are lots of quality incentives in place to try to push nephrologists to get those fistulas and grafts in place earlier so that

patients are avoiding catheters all together. So when I say that catheters are low quality, it's for a variety of reasons and I think that there is general consensus from both CMS, CMMI, nephrology, from all of us that we should be using less catheters. Unfortunately, catheters are the easiest thing to do in the hospital. So when our patients come in, there's very little emphasis placed on getting them to dialysis with the right access. The emphasis is then getting them to dialysis and that's often done with placement of a temporary catheter. It causes all kinds of issues. And I think if you looked at the Dobson study, you know, there was -- when we were looking at hospital-based care for dialysis patient accesses, there was a 30 -- 30-something, 38 percent higher infection rate because of that, because of the reliance on catheters. When we move those patients back out to our outpatient vascular access centers, all of these things improve because our priorities all become aligned, and when nephrologists are driving access, good things happen for patients. So we would like to keep this care outpatient however we can manage to do that.

DR. MCKENZIE: Thank you. I just wanted to comment that I asked that question because, you know, I had a little bit of awareness. I think you really helped that. But we've also looked at -- in these patients we call it

kind of crashing to dialysis where these catheters get placed and the cost of treatment when you start looking at total cost of care for these patients becomes much higher because of the complication rates. And it's -- it's -- frankly, it's just not as good of patient care. And CMS is recognizing that and there are quality measures coming out about more planned kind of putting in the fistulas and doing that earlier. And so, you know, I think that that all needs to be considered, I guess, you know. I don't know if I'm supposed to be kind of weighing in on my -- my leaning, but I do think this is an important issue to be considered. I don't know what the outcome is. There's definitely the slippery slope piece that has to be considered. But I think with where the market is going, I don't think we want to see these procedures lag in the opportunities to get them in the outpatient space disappear.

DR. VIDOOSHI MARU: And we do participate in value-based care with CMMI. So we're involved in the KCD (sic) programs. That is a piece of this, too.

DR. MCKENZIE: Thank you.

MR. FALAHEE: Beth, I see you had your hand up?

MS. NAGEL: Yeah. I just wanted to give a little context for the Department's recommendation to look at this in a SAC. Some of you may remember -- I can't remember who was here or not -- but I think about three or four years ago

a different organization came to the Commission and presented almost the same, you know, idea and at that time they came very late. Like, we -- you -- I think you were about to take final action on the Surgical Services and they came and presented this and the Commission said, "nope, you're too late, next time." And so from our perspective this is the next time. We don't know the outcome either. We don't propose to know how this would work in the construct of our -- you know, our standards. We have the same concerns that you all have addressed, but we thought this was the right opportunity to get the experts together in a room and have this conversation. And, you know, depending on how it turns out we may, you know, weigh in for it or against. I don't know. But we didn't want to miss this opportunity.

DR. VIDOOSHI MARU: And I will say it was a little bit different only in the sense that they were coming to you to ask for permission to do the same thing but for a different reason. They wanted to participate in a value-based care program with dialysis patients that coupled vascular access care with dialysis. So it was a pilot program and it was a very small subset of patients that would have sort of been covered by this. We are coming to you with an ask to help us in the care of all of our dialysis patients because this is the best thing for them.

MR. FALAHEE: Other questions? Are there additional com- -- I think there are. Okay. Thank you.

DR. VIDOOSHI MARU: Thank you very much for your time.

MR. WIRTH: Next I have Linda Rahm of the Lifeline Vascular Care.

LINDA RAHM

MS. LINDA RAHM: Members of the Commission, it's a pleasure to be here to share my comments. I'm pretty much going to rip up my paper because you have all asked, you know, some of the same questions and Dr. Maru has kind of given you the background around these patients.

You know, like he said, my name is Linda Rahm. I'm part of Lifeline Vascular Care. We have 40 nephrology based centers across 24 states, but I've been in the ASC world for nearly 40 years and I can tell you when I'm in my other life with multispecialty that we never accepted nephrology patients at our multispecialty surgery centers. Most of these patients, as Dr. Maru mentioned, have highly specialized needs and a lot of attention. In our centers, our staff spend a lot of time working on, you know, dealing with Hoyer lifts, dealing with their other co-morbidities, working on -- working with the Social Services and transportation. And so, you know, our main -- our main goal is to get the patients in within 24 hours for access care so

they don't end up having to have, you know, fistula grams done, have CVCs put in, all those things that add to extra preventable cost to the system, hospital stays, infections, et cetera.

I want you to keep in mind that, you know, dialysis patients, as you mentioned, represent probably one of the highest per capita costs to our healthcare system. As an example, it's an old one, but in 2016 less than one percent of the people cared for by Medicare and Medicaid were dialysis-related patients but it was over seven percent of their budget and it's only grown since then. And they have worked very, very hard to try and cut those costs by putting in kidney care initiatives which started in about 2019. So since 2019, CMS has been trying to drive these cases from the hospital and from other centers to a controlled setting and they see the ASC as that controlled, lower cost, less invasive place for care. And, again, I want to, you know, reiterate that for our nephrology practices that are out there, those that were able to convert or move into an ASC, they're my success stories. Those others that are left are having the hard decision of whether to shut down and go back to their pre-access center quality measures and that is not a place we want to go.

So I think, you know, for us you need to understand that there's a lot of attention on special care

that's required with these patients at the setting and they're not -- they're at the bottom of the list if a surgery center is going to invite you in because of the amount of the time, the amount of the care that it takes.

So, again, just to reiterate, these are cases that are already being done. I commend Dr. Maru and her practice in 20 years ago having the foresight to take these things out of the hospital and putting them into an access center and giving the best care that they could. And I feel now they're -- because of the way the CON rules are written, it is penalizing them for having done that in the past little bit. And I appreciate you considering the SAC. Any questions?

MR. FALAHEE: Thank you very much. Any questions? Thank you for your time. Appreciate it. And your letter.

MR. WIRTH: Next up, Patrick O'Donovan of Corewell.

PATRICK O'DONOVAN

MR. PATRICK O'DONOVAN: Good afternoon once again. My name is Patrick O'Donovan. I'm here again representing Corewell Health. We agree that there are a multitude of issues related to Surgical Services and we support the Department's recommendations to form a SAC.

There is one item that I'd like to comment on for a potential charge if a SAC is formed. As you may recall,

during the last review of the Cardiac Cath standards, significant changes were made to allow for cardiac cath labs in freestanding surgical outpatient facilities. This change was made to align with CMS regulations and to create additional access to these services at a lower cost. While it was recognized at the time of the last Cardiac Cath SAC that allowing cardiac cath in freestanding surgery centers could also impact the Surgical Service standards, it was concluded at that time that any proposed changes to the Surgical Service standards were our scope for that SAC and would have to be addressed separately. One example is the applicable maintenance volume requirements for a FSOF dedicated exclusively to cardiac cath services. While the maintenance cath lab values -- volumes are included in the new Cath Lab standards, a question is whether a dedicated cardiac cath lab FSOF should have different surgical volume requirements. For example, if a dedicated cardiac cath lab FSOF has to meet both the cardiac cath lab and the current surgical maintenance volumes separately and without the ability to double count them, this could result in a dedicated cardiac cath lab FSOF that is meeting the cath lab maintenance volumes, but could still be subject to compliance for not meeting the traditional FSOF surgery maintenance volumes. Accordingly, we ask the Commission to approve a SAC charge to review and clarify volume

requirements for FSOFs that are solely dedicated to cardiovascular services. Again, thank you for your time and I'd be happy to respond to any questions.

MR. FALAHEE: Questions from the Commission? So, Mr. O'Donovan, what you're talking about is to allow double counting?

MR. PATRICK O'DONOVAN: Well, what I'm saying is that if you -- if you do not allow double counting -- let's say it's a dedicated FSOF with one OR dedicated to cardiac cath, they have to meet the cardiac cath volumes that's stated in there while they're also an FSOF so they need to meet the surgical volume as well. If you require that they meet both the cardiac cath and the surgical ones separately, I'm not sure you have enough capacity and then you're subject to compliance action. So we're just asking that that be looked at as part of the work of the SAC.

MR. FALAHEE: Other questions? Let me ask a question of the Department, probably Tulika. Has this come up before, the issue of a cardiac cath lab used exclusively for cardiac services -- an outpatient cardiac cath lab, right, as an FSOF meeting the cardiac cath lab requirements and the FSOF requirements? Has that come up yet?

MS. BHATTACHARYA: So we have approved three FSOF cardiac cath projects so far. I don't believe they have started operation or we don't have data. So I cannot really

speak to that. So I would say no, it hasn't, but typically, you know, when you have an operating room, that is held to the surgical standards volume requirements and when you have a cath lab, that is held to the cath lab volume requirements under the cath lab standards.

MR. FALAHEE: Right. And these are so new that we really haven't grappled with the issues that Mr. O'Donovan is talking about; right?

MR. CONNOLLY: Marcus from the Department. I know that one facility, MOBI (phonetic), they have gotten started. I seen them on a -- actually, on a LinkedIn saying that they've got everything started. But like Tulika said, we don't have any data back yet to be able to make an assessment one way or the other.

MR. FALAHEE: So Mr. O'Donovan's point is seeing this issue potentially on the horizon, let's talk about it?

MR. PATRICK O'DONOVAN: Yes, this is -- yes, because it wouldn't have come up yet because there --

MR. FALAHEE: Right.

MR. PATRICK O'DONOVAN: -- nothing has been there long enough. So it's really kind of addressing it -- I mean, it will become an issue down the road if it's not addressed.

MR. FALAHEE: Right. And as usual, you're trying to get ahead of the issue. Any other questions?

MR. PATRICK O'DONOVAN: We sent in our comments.

MR. FALAHEE: All right. Thanks a lot.

MR. WIRTH: That was the last public comment card I had for this section.

MR. FALAHEE: Great. Commission Discussion? Any comments, discussion from anybody? I'll -- let me ask a question. I'm going to sort of pretend I'm Commissioner Turner-Bailey and ask a question about SAC versus workgroup. So put Kenny on the spot or anybody on that other side of the table. There's a reference or recommendation that this be a SAC. Why that versus a workgroup?

MR. WIRTH: This one was slated for a Standard Advisory Committee just due to the length of the number of charges to get through. That was our thinking on this was that there could be some potentially contentious ones on this list and then also being able to use the SAC setting to parse out which groups, subgroups potentially work on which charges.

MR. FALAHEE: Okay. Any other comments? Other questions? Discussion? So, Kenny, let me -- from what we heard from our witnesses, there's one suggested add-on and that's -- well, it's actually -- you've already got in here language about "review the volume requirements for ASC to accept dialysis access procedures performed in office-based labs." And you think that that's sufficient to hear what we

heard Dr. Maru --

MR. WIRTH: We can -- we can tweak it with the testimony she provided to give that charge.

MR. FALAHEE: Okay. Understanding that there are issues on both sides on that one?

MR. WIRTH: Yup.

MR. FALAHEE: Slippery slope versus patient care, okay, cost and all. Okay. And the other one, Mr. O'Donovan's comment just now about the volume requirements for an exclusive cardiac cath lab that's outside, it's in a -- that would be another -- if we agreed as a Commission, that'd be another added charge?

MR. WIRTH: Correct; yes. And the first one wouldn't be added. That's already included with our recommendations to you. It'd just be tweaked slightly.

MR. FALAHEE: Got it. Okay.

DR. MCKENZIE: Is it one added charge or is it two? Because I saw that -- I'm not sure if it's the review Sections 3 and 11 to allow excess cardiac cath volume to count for initiation and there was also a revised to allow cardiac cath labs in freestanding that are used exclusively for -- which one is it?

MR. FALAHEE: Second one.

DR. MCKENZIE: Because there were two that were listed as "no." I don't know if it includes both of those

or if it includes one.

DR. ENGELHARDT-KALBFLEISCH: I thought one was initiation and one was maintenance maybe.

DR. MCKENZIE: Yeah, I think you're right. I think both would have to be considered; right? I mean, wouldn't it? Because this is a new issue?

DR. ENGELHARDT-KALBFLEISCH: I mean, to me they're very different, but I don't --

DR. KONDUR: I think initiation they do have a standard set in place already.

DR. MCKENZIE: Okay.

DR. KONDUR: Maintenance is the one --

DR. MCKENZIE: So it's more the maintenance.

DR. KONDUR: -- how do they count the procedure programs from the cardiac ASC, that's where the clarification. You have to maintain both surgical volume and cath, so it's to the transfusion of that.

DR. MCKENZIE: Yeah.

DR. KONDUR: Whether you count only a c volume cardiac -- a c volume to the (inaudible).

DR. MCKENZIE: Yeah. Okay. That makes sense. Thank you.

MR. FALAHEE: Other questions or discussion? If not, I'll entertain a motion if anyone should choose to make one.

DR. MCKENZIE: I will move to seat a SAC to address the charges that were laid out by the Department with the addition of one additional charge related to consideration of cardiac cath maintenance volumes counting toward surgical services for freestanding outpatient, as well as a revision to the language related to dialysis access and how we count that, with delegation of the final language of those charges to the chair, as well as choosing the chair of the SAC to the chair as well.

MR. FALAHEE: Is there support for that motion?

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleish. Support.

MR. FALAHEE: I'm looking at Kenny to make sure that what the motion there is everything that we put in our usual SAC approval?

MR. WIRTH: (Nodding head in affirmative)

MR. FALAHEE: Okay. All right. Okay. We've got a motion on the floor. Any discussion? All in favor please raise your hand.

ALL: (all raise hand)

MR. FALAHEE: Anyone opposed? Great. That motion carries.

(Whereupon motioned passed at 1:20 p.m.)

MR. FALAHEE: I'm giving Kenny a chance to catch up on his notes here before we move on to the next agenda

item.

MR. WIRTH: My hand only moves so fast.

MR. FALAHEE: Next we go to our Surgical Services -- no, sorry -- Hospital Beds, recalculation of bed need numbers setting effective date.

MR. WIRTH: Yup. So this is the biannual update of the bed need numbers in the LAAs. Dr. Paul Delamater on behalf of the Department has done the recalculation pursuant to Section 5(2) of the Hospital Bed standards. He's provided a report summarizing the charges in your packet. Pursuant to Section 5(3) of the Hospital Bed standards, the Commission is required to set the effective date of the bed need numbers. The Department is recommending making the new bed need numbers effective on March 1st, 2023.

MR. FALAHEE: Any questions of Kenny about that? Otherwise we can entertain a motion to that.

DR. MCKENZIE: I'll move to set the effective date to March 1st for the new bed need calculation.

MR. FALAHEE: Is there support for that motion?

DR. MACALLISTER: Macallister. Support.

MR. FALAHEE: Thank you. Any discussion? All in favor of that motion please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Any opposed? Okay. That motion carries.

(Whereupon motion passed at 1:22 p.m.)

MR. FALAHEE: Next legislative update.

MR. WIRTH: Yup. And just it was Macallister on the second for that one?

DR. MACALLISTER: Yes.

MR. FALAHEE: Yes. Sorry.

MR. WIRTH: Thank you. No, you're good. Okay. So legislative update. So as I mentioned during our Hospital Beds discussion, Senate Bill 183, which is now Public Act 265, was signed into law and made effective as of December 22nd, 2022. SB 183 amends Part 222 of the Public Health Code to allow a licensed hospital located in a non-urbanized area to apply to de-license temporarily 100 percent of its licensed beds for up to five years per hospital for an REH. It requires that CON continue to count the temporarily de-licensed beds for the purposes of determining hospital bed need, and this was included in your request for the HB workgroup or SAC, sorry. And as of yesterday, January 25th, the MRI and MRT standards that were sent to the JLC on September 27th, 2022, have reached their nine legislative session days, so as of today those standards are effective for MRI and MRT. And that's all we had for a legislative update.

MR. CONNOLLY: That's it.

MR. FALAHEE: Okay. I'll just add -- this is

Falahee. There's obviously a whole cadre of new legislators. There's, I think, 56 new legislators, 58, something like that, so a large number. In the committees of jurisdiction in the house, the House Health Policy Committee, the chair there is Julie Rogers from Kalamazoo, Portage. I'm meeting with her Monday morning to talk about healthcare issues at her request. In the House, the chair of the House Health Appropriations Committee is Christine Morse from Kalamazoo. I haven't set up a meeting with her yet, but it's going to be coming. So, and we'll see what happens within the House and the Senate in terms of any impact on us. Typically with a democratic administration you don't see challenges so much to the CON process and that's just typical of a republican versus democratic administration. That's neither here nor there. But you deal with what comes down the pipe. And I'll help supplement what Kenny comes up with on legislative updates as I see what's going on. That's it. Any questions? All right. Moving on, Administrative update. And you're still up, Kenny.

MR. WIRTH: Yes, I'm still -- still at the plate. So for appointments, we have been in close contact with the Governor's appointments office. I am anticipating those coming through before our March meeting so we'll know where everyone stands on that as well as possibly new

commissioners, at least one to fill Lalonde's seat. Another update I have -- and I need to preface this by saying my bar for excitement is apparently extremely low at this point in time. There's movement on Air Ambulances. And I know I said that last January, but we actually have movement. The administrative rules package was sent to the Joint Committee on Administrative Rules on January 23rd. I have had to sit through that lengthy JCAR review process before, so in my previous experience it's been about three to four months before they're effective. So I'm hoping that we'll be able to have something at the June meeting at the latest to say we're ready to begin deregulating and we'll be able to help you through that process once we get to that point. But I was over the moon to see that those had been submitted to JCAR because it's been since 2009 that we have said that we're going to deregulate air ambulance. So, again, really low bar for excitement nowadays, but nonetheless very excited.

MR. FALAHEE: I think that -- I joined the Commission in 2009 and it was one of the first items we took up and it took that long to get the rules put together to complete the puzzle. That's good news.

MR. WIRTH: And that's all from our Commissions and Special Projects section so I'd toss it over to Tulika for an evaluation section update.

MS. BHATTACHARYA: Thanks, Kenny. So the first update I would like to provide to inform the CON Commission that we are down by all three program review specialists. One person retired, Marcus got promoted and Shannon also left for a promotion, took another job with LARA. But we are hiring. Tiffany Wilkinson who used to be the compliance analyst for the Department is now the review specialist for MRI, PET, Cardiac Cath, Open Heart and Lithotripsy Services and we are hiring for the other two positions as well. And I wanted to assure that we are continuing to review an issue that has risen seven times so far and I sincerely hope that we would meet -- still meet all of our deadlines. And it's incredible teamwork. Everybody is helping out.

Also, you have the annual report for FY 2022 in your packet. It has been a long meeting, so I don't really want to go over this big report, but if you have any question about any of the charts or you see a trend or some numbers that does not make sense to you, please just send me an e-mail. I'm more than happy to explain it to you or provide the data to you how we came to that conclusion. But I would also like to take this opportunity to thank our project coordinator, Ashley Mayor, for her help in preparing this big, detailed report, all of the data, charts in it. And that's my update.

MR. FALAHEE: And I echo all the work that goes

into this report. We have no idea all that goes into it. I work with Tulika a lot and it's amazing what the Department does and the work that goes into this report. And I talked to Tulika about something else and she told me about the staff departures and one of whom was a long-time person with the Department that retired and two others, so I've got confidence that she'll fill it, but many people over the last couple three years that have been with the Department 30, 40 years have left. So we're dealing with some new folks, but they're good folks and they're working with a very good person in Tulika in running the Department. So, Tulika, thank you for all that you do with that group, an ever changing group. So thank you. Now, Legal Activity report.

MR. HECKMAN: Assistant Attorney General Brien Heckman. Thank you, Chairman Falahee. I just have two items on the Legal Activity report: Havenwyck Hospital versus the Department, that is essentially the same parties in the same health service area as Pine Rest versus the Department from last year, also involving psych beds. The parties have all submitted motions for summary disposition. That will hopefully resolve the case without a trial. The responses to those are due on the 10th, I believe, and I anticipate it being resolved with these motions because it's essentially a legal issue. There's not really a factual

dispute. The second item is U.S. v Angelo and that's just a subpoena to the CON section for records. Ordinarily places will accept a certificate or certification for documents, but because this is a criminal case, the defendant has the right to confront the witnesses. So hopefully they just accept a certification because otherwise Tulika and I are going to be driving down to Detroit. That's it.

MR. FALAHEE: Any questions? Who's the judge in that case, do you remember? Just some of the judges are classmates of mine, that's why I was curious. All right. Thank you. Okay. Other public comment. Kenny, do you have any other public cards?

MR. WIRTH: I don't have any blue cards for general public comment. So I -- I'm looking around, not seeing --

MR. FALAHEE: Okay. I'm looking around. I don't see -- it's the diehards that remain. None of them dare make any public comment. All right. Thank you. All right. Review of Commission work plan.

MR. WIRTH: Yes. So with -- you should have a copy of the current work plan in your binders. With today's changes we are going to be extending the Psychiatric Beds and Services workgroup for a couple more meetings since they'll have to go into some more charges on that. We will form a Cardiac Catheter -- Catheterization Standard Advisory

Committee. We will also be forming a Hospital Bed Standard Advisory Committee, a MRT workgroup, an Open Heart Surgery workgroup, and a Surgical Services Standard Advisory Committee. So if the Commission has any requests for which should be prioritized first, we are happy to hear those and work with that while we're revising the work plan.

MR. FALAHEE: Let me suggest based on what we have heard. I think of the three SACs, the Hospital Bed should be priority number one. As to the other two SACs, I really -- doesn't matter to me unless anybody from the Commission wants to prioritize? Okay. Is that enough? Does that --

MR. WIRTH: Yeah. We will prioritize Hospital Beds and get that nomination period opened as soon as we can.

MR. FALAHEE: Okay.

MR. WIRTH: We currently have Psych Beds running. I'll look to Mr. Haney. I think we're about to wrap on Nursing Homes at the February meeting is the last -- we have one more scheduled after that I think in March?

MR. HANEY: We have February and March.

MR. WIRTH: February and March. So we're coming up at the end of that. So we'll get another workgroup probably started after nursing home wraps while we're doing the nominations for Hospital Beds and then we can provide an

update in March for how nominations are going on that.

MR. FALAHEE: Okay. Thank you. And you need a formal action for the Commission to approve the work plan as revised; right?

MR. WIRTH: Yes.

MR. FALAHEE: I'd entertain a motion for that, please?

DR. MCKENZIE: I'll move to revise the work plan as discussed with prioritizing the Hospital Bed Standard Advisory Committee.

MR. FALAHEE: Support for that motion?

DR. KONDUR: Commissioner Kondur in support.

MR. FALAHEE: Any discussion? All in favor please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Okay. Opposed? All right. That motion carries.

(Whereupon motion passed at 1:33 p.m.)

MR. FALAHEE: Next future meeting dates, just so everybody's got it, it's on our calendars, but March 16, June 15, September 14, and December 7th, which will be here before we know it. Anything else to come before the good of the order after a four-hour meeting? All right. I'm not going to hear anything. I will entertain a motion to adjourn, please.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt. Motion to adjourn.

DR. MACALLISTER: Macallister. Support.

MR. FALAHEE: Okay. Macallister support. All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Raise your hand. Thank you very much. Thank you, everyone, here at the Commission table and around the room. Very good discussion on many, many issues. Thank you.

(Proceedings concluded at 1:34 p.m.)

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